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ABSTRACT

Changes in the delivery of health care services and their implications for nursing practice and nursing education are discussed in nine papers from the 1986 annual meeting of the Southern Council on Collegiate Education for Nursing. Titles and authors are as follows: "Changes in Health Care and Challenges for Nursing Education" (Jacquelyn S. Kinder); "Redesigning Nursing Education Curricula to Meet Changing Needs" (Verle Waters); "Redesigning Nursing Education Curricula to Meet Changing Needs: Implications for Doctoral Programs" (Billye J. Brown); "Redesigning Nursing Education Curricula to Meet Changing Needs: Implications for Master's Programs" (Joan Farrell); "Redesigning Nursing Education Curricula to Meet Changing Needs: Implications for Bachelor's Programs" (Margaret L. McKevit); "Shifting Patterns of Nursing Practice: Impact on Associate Degree Nursing Education" (Margaret G. Opitz); "Theory-Based Nursing--The Foundation for Practice and Education: A Nurse Administrator's View" (Sarah E. Allison); "Alternative Approaches to Care for the Elderly: What Nurses Need to Know" (Miriam K. Moss); and "Unity in Nursing--A Public Imperative" (Virginia M. Jarratt). (SW)

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Shifting Patterns of Nursing Practice: Impact on Nursing Education

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Shifting Patterns of Nursing Practice: Impact on Nursing Education

Papers Presented at the 1986 Annual Meeting

of the

SOUTHERN COUNCIL ON COLLEGIATE EDUCATION FOR NURSING

SOUTHERN COUNCIL ON COLLEGIATE EDUCATION FOR NURSING
592 Tenth Street, N.W.
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FOREWORD

The annual meeting, October 28-30, 1986, provided a forum for the Southern Council on Collegiate Education for Nursing to discuss changes in the delivery of health care services and their implications for nursing practice and nursing education. The Council, whose membership includes all levels of college-based nursing education programs, addressed topics of mutual concern to all of nursing education--such as the question raised by Verle Waters on a multiform vs a uniform system of nursing education, Sarah E. Allison's plea for theory-based nursing as the foundation for both practice and education, and Miriam Moss's admonition that, "We do not assign students without a good basis in pediatrics to an 8-year-old surgical patient. Why do we allow students to take responsibility for an 80-year-old surgical patient without such knowledge base in geriatrics?"

In response to Verle Waters' paper on overall curricular concerns, speakers addressed specific considerations for associate degree, baccalaureate, master's, and doctoral education programs.

Papers presented at the meeting are contained in this publication.

Audrey F. Spector
Executive Director

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CHANGES IN HEALTH CARE AND CHALLENGES FOR NURSING EDUCATION

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President
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Things have not been "business as usual" in health care for some time now. The government is still extremely worried about soaring costs in health care; our rate of spending in the health sector is still much higher than in other sectors of the economy. Although some policymakers claim we haven't accomplished all that much in the way of controlling health costs through Diagnostic Related Groupings (DRGs) (people like health economists Eli Ginzberg and Uwe Reinhardt claim that we're just shuffling the deck chairs), the new DRG system of prospective payment, which ushered in a health care revolution several years ago, is still proceeding at a breakneck speed.

The extraordinary changes that have occurred since the introduction of DRGs have placed us on the verge of the evolution and development of a true health care marketplace. Wall Street has discovered health care and, in this DRG era, thousands of new health care businesses have sprung up on the stock exchange. Indeed the corporatism of health care is upon us, for better or worse.

Health care decision makers' attention these days is focused on product line management, customer relations, and bottom lines. Productivity, profitability, and competition are driving the vectors of change in health care. The results are massive restructuring and rampant diversification into wellness centers, cardiac rehab centers, pizza parlors, hotels and motels, and even parking garages to buttress ailing profit margins in hospitals. There is not a single hospital chain in the nation that is not involved in a business venture that is completely unrelated to health care. The latest rage in ventures among several of the for-profit chains is the insurance business. Hospital Corporation of America (HCA), in conjunction with Equitable, Humana, National Medical Enterprises--all looked to the insurance business as the great white hope for redeeming operating losses as a result of declines in the volume of in-patients.

Such innovative revenue-enhancing tactics, say many industry observers, merely forestall the inevitable. Hospital occupancy has suffered a permanent

decline. According to a study conducted by the consulting firm of Arthur Andersen and Company and the American College of Hospital Administrators, hospitals will continue to get a smaller share of the nation's health dollars.[1] They'll receive only 38 cents of every dollar spent on medical care in 1985, compared with 42 cents in 1982.

The Andersen study also found that the number of hospitals owned or run by hospital multisystems or chains has increased five percent in the past five years. Today more than 35 percent of hospitals are part of a health-care system--nearly 15 percent of those are owned by for-profit chains. By 1995, the Andersen study said, most hospitals will be owned, leased, or managed by multihospital systems. Many others have forecast that a handful of hospital chains in the nation will swallow up other providers, including home health agencies, and that eventually a few hospital chains will own and control all the free-standing agencies and independent enterprises in the nation.

I think it is becoming increasingly clear that this scenario won't pan out. Anxious to diversify when their in-patient volume took a nosedive post-DRGs, the powerful hospital management companies are the best example of that foiled plan. Humana, for instance, is suffering a major loss as a result of its foray into the insurance business. HCA, which was not quite as aggressive, is not suffering as great a loss but the new venture is not the great savior it was expected to be.

In addition, as biomedical advancements increase, the physical hospital will likely be smaller because patients will be able to function in their homes as life-support and maintenance technologies are made more easily accessible to the average person. Under these circumstances the hospital industry may well shrink dramatically into second place, giving rise to home care as the major type of health care in this country.

Home care is currently the most rapidly growing component of the health system and it is projected to grow at as rapid a rate in the future.

This major trend is a result of the new prospective payment system and the burst of activity in the home care and community areas. Naturally, because length of stay is a critical variable in a hospital's expenditures, under the new system hospitals have been discharging patients sooner and sicker. There has been a 33

percent increase in admissions to home health agencies in the past two years. Currently over 60 percent of all nurses in the United States are employed in hospitals; it is projected that by the year 2000 that will be as low as 39 percent.

This shift away from acute care to the home and community is a highly favorable trend for nurses because nurses have always been and continue to be the primary providers in the home and community. In addition, because of financial pressures, policymakers and insurers are far more receptive to diversifying and developing alternative modes of health care delivery than ever before. Nurse-run enterprises could be established in a variety of ways. Many nurses in community mental health already have established businesses to provide counseling services. Individuals and groups in private nursing practice in the community could provide services and consultation to clients in homes, schools, industries, and clinics. Nurses could own and operate adult day care centers, home health care agencies, nursing homes, and hospices. The general push to get patients out of the hospital sooner, preventing them from entering the hospital, and to use home care services and other alternatives in lieu of costly acute care in patient services, means increased demand for these services for which nurses are the predominant caregivers.

Another highly favorable trend for nurses is the changing demographics of the population in this country. It is predicted that by the year 2020 the elderly population will have doubled. The elderly tend to have chronic illnesses that require nursing care, not acute medical care. Medical care is not only extremely expensive when applied to chronic illness, it is also inappropriate and ineffective. Because of cost pressures and a growing demand for care that consists of more than drugs and surgery, policymakers and insurers are more receptive than ever to what nurse providers have to offer. Nurse-run Preferred Provider Organizations (PPOs), Health Maintenance Organizations (HMOs) that provide nursing care on a pre-paid capitated basis for chronically ill populations, midwives or pediatric nurses, and nurses in mental health group practice could establish alternative delivery systems that operate with a holistic, humanistic approach.

Change is everywhere in health care, and many of these changes clearly make this a time of great opportunity for nurse providers. Nowhere is this more apparent than in the attitudes of consumers and their growing concerns about the quality of care they receive and their rights in the system.

A publication of the American Association of Retired Persons, Medicare's Prospective Payment System: Knowing Your Rights, has been a best seller for some time. Recently the Institute of Medicine published a study of nursing homes calling for a greater say for patients in the policies governing the care they receive.[2]

The importance of consumerism in health care was elegantly summarized by Susan Jenkins, a Washington, D. C., attorney who has represented several nurses and nursing groups fighting for greater consumer access to nonphysician care. In the closing remarks of a television program entitled "Health Care Turf War" she noted that in this country there is a very important consumer movement right now--to take control of their own health care and not to allow physicians to tell them what to do.

Jenkins has argued several cases in which nurses have challenged the status quo and fought to make their cost-effective services more accessible to consumers--and won. She cites the ground swell of public sentiment in favor of her clients and the growing willingness of government officials to side with her clients' cases.

Consumers want better, more holistic care, and more information about the care they receive from physicians. National opinion polls show a steady worsening of public opinion concerning the medical profession. In 1984, 68 percent agreed that "people are beginning to lose faith in doctors." In addition, only 27 percent of those surveyed felt that doctors' fees are usually reasonable.[3] In fact, in recent years, physicians' fees under Medicare grew at an annual rate that was 18 percent faster than any other component of the federal budget.[4] To date, the American Medical Association has failed to get Congress and the White House to lift a freeze on Medicare physicians' fees or to stop a trend toward more restrictive fee systems in general.

Public sentiment is likely to be highly receptive to offering consumers their choice of provider, and consumer choice is more and more likely to rest with the provider who is willing to provide high quality care at a reasonable cost.

Never has there been a period of such radical transition in health care, except possibly for the enactment of Medicare 20 years ago. And, as I've tried to point out, many changes are clearly opportunities for nurses to gain greater influence in the policies that govern the delivery system and to gain greater independence and control over nursing practice as well. It is our window of opportunity, as they say.

Just as it is apparent that health care is undergoing revolutionary change, it is equally apparent to many that our educational system is not changing rapidly enough to keep pace with it. It is probably safe to say that in the majority of schools of nursing major changes have not taken place to teach students how to enter a very different world that is characterized by profit motives and competition. By and large we have not altered our curricula to teach students about how health care is financed or about the Medicare system as the largest purchaser of health care. We have not altered our student placements to reflect a shift that is taking place from the hospital to home and community-oriented care, even though it is projected that there will be a 25 percent decrease in acute care jobs for nurses by the end of the century. And, we have not altered our programs to reflect the opportunities nurses would have if they knew more about pooling capital resources and investment. We have not instituted values clarification classes to examine the benefits and the potential detriment of a health care system that is increasingly run for profit and by investor-owned companies. The implicit message that the student receives is: The problems that exist in health care are not your problems, therefore they are not your responsibility to think about or to resolve. All you need are the same basic nursing skills no matter how much the system changes because you'll be doing the same thing.

I fear that in our zest to become truly accepted in the academic community, we find ourselves caught in a dilemma of needing to change when we've not yet gotten used to the tradition of academia. The crux of the dilemma is this: We have become so enamored and engaged in the principles of education, we may have forgotten that our ultimate goal is to educate. And secondly, many have forgotten that we are educating individuals to enter a practice profession that entails caring for human lives. That is to say that there are probably only a few curricula in the nation that teach students the fundamentals of how health care is financed in this country, or how nurses are reimbursed for their services under Medicare, or what policy initiatives are taking place regarding competition among providers, or even the ethical dilemmas of the prospective payment system that is revolutionizing health care.

If we can observe a very significant shift occurring in the environment from acute care to the home and community, nursing students should be urged to establish independent practices, to consider taking the initiative to look at where the need is

for their skills, and to "market" those services. The early discharge phenomenon provides multiple opportunities for nurses to provide follow-up care to hospitalization, either in the home or in nurse-established and nurse-run community centers. In our leadership and public policy courses students should learn that the financial incentives in the system mitigate against providing "holistic" care in the home and that, instead, reimbursement arrangements are set up for an acute care model.

These defects in the reimbursement system for home care are very well known to those in the field. If nursing students are graduating into a health care world where home care will be the predominant mode of care delivered in the country, they should know these defects and know how to change them, and be taught that it is their responsibility to change them--if they want patients to receive good and effective care.

Home care is still paid for on a cost basis while prospective payment is widely recognized as being superior. Home care is paid for on a visit basis even though fee-for-service payments are known to create incentives for increased volume. Home care coverage fails to provide some of the services needed by patients being discharged from hospitals earlier in their convalescence than they used to be. And, home care coverage decision takes only haphazard account of the extent of the patients' impairments and of the patients' nursing care needs. Home care studies clearly show that physicians provide inadequate orders, design inadequate treatment plans for patients in the home, and that nurses provide the care needed regardless of eligibility.

As the major providers of home care, these deficiencies are our problem as well as the patients' problem and, as such, are our responsibility to address in nursing curricula--graduate and to some extent undergraduate. If nurses do not educate students to take the initiative in situations of this nature, either nothing will be done or others will take charge, as they have in other areas of health care. Students must be taught to understand the financial incentives in health care and how they can be altered, for they are the levers of control for nursing practice--in and out of the home.

I would like us to see in schools of nursing more curricula in which the main principles were risk taking, living with ambiguity, and taking the initiative in health

care today. I concur with the great philosopher Immanuel Kant, who said the three questions that should form the core of any great curriculum are: What can I know? What should I do? and What may I hope? Kant's questions can be readily applied to our own profession.

For example, in the study of nursing we might ask: How would one fashion a health care system characterized by holistic care and compassion, where psyche and soma are not dichotomized and that seeks to include spiritual knowledge and values as well as technical proficiency? How would it differ from what we currently have? What should we do to provide the best care possible to reduce human suffering and contribute to our knowledge of how to obtain ultimate health status and well being.

Because of the way our highly competitive, productivity-oriented health delivery system is structured, in nursing higher education we must walk that fine line of giving students enough of what is immediate and useful, but continuously guard against too much emphasis on the useful and practical, too much over-specialization, and, rather, emphasize the development of the completeness and the unity of man throughout the life cycle. At one time we all believed that eventually medical science would know all that there is to know about the causes and cures of illness. We have been led to believe that specialized technology is the answer to our problems in health care. In such a view of the world, the ultimate questions posed by philosophy and metaphysics have been pushed aside in favor of the more practical scientific and utilitarian ways of solving problems. In many ways, the limits of this thinking and a medical system that reflects this thinking are upon us.

A close examination of health care trends would reveal, even to the most uninformed, that we have reached the practical limits of medical science and are clearly on the verge of realizing diminishing returns from use of the medical model. Califano expounds on the diminishing utility of the medical model.[5] He cites how our nation has experienced a dramatic 25 percent decline in deaths from coronary heart disease since 1970. Improved eating habits, resulting in lower cholesterol levels, accounted for almost one-third of the drop. The decline in cigarette smoking was responsible for another quarter. So, by changing personal habits, individuals were responsible for more than half the decline in deaths from heart disease.

We have reached the limits of medical science and have entered a new world of health care in which prevention, nutrition, and life-style factors are the keys to

wellness. These factors are outside of medicine's traditional domain, but medicine is fast claiming them. Make no mistake: medicine will not hesitate to claim traditional nursing concerns as its own.

Physicians themselves are acutely aware of the need for a new paradigm in the delivery of health care, driven by a new era in societal needs. Fries has asserted that the medical model of disease grew out of and is more appropriate to the infectious disease era when smallpox, typhoid fever, syphilis, and polio were the prevalent problems.[6] Now deaths and mortality from these causes are down over 99 percent in the aggregate. The era of acute infectious disease is over, along with the appropriateness of the medical model for working with people and their health status.

Arteriosclerosis in all of its guises, cancer in its many forms, diabetes, emphysema, cirrhosis, and arthritis now make up the overwhelming majority of the illness burden. They require theoretical and practical approaches that emphasize psychosocial, emotional, and behavioral patterns of care.

Therefore, I believe that nursing curricula as a humanistic health discipline in an age of rapid change, in an age where many of the ways of our traditional system which were defined and developed in accordance with the tenets of medical science are no longer working, must dramatically shift. Nursing curricula should be aimed at fundamental and ultimate questions about human needs, in illness and in health, about political questions concerning the allocation of resources said to be inadequate in our health care system, about the economic relationships between health care and other sectors of society, and about moral questions concerning who shall live and who shall decide.

Clearly our curricula in nursing schools must be reshaped and reformed to keep step with the rapid changes that are occurring in our health care system and in society. But just as clearly the problem is not just curricula, it is our educators and the calibre of teaching in postsecondary education. Several reports have been released in recent years indicating that not just nursing education but the whole of higher education in this country is inadequate and in trouble in many ways.

Last year the American Association of Colleges released the results of a study that talked about the "impoverished nature of the baccalaureate degree."[7] The

study cited several fundamental areas of weakness in postsecondary education, including nursing but not particular to nursing. The report charged that we are turning out students who have inadequate communication skills, inadequate analytic and logical thinking skills, and an inadequate grasp of our historical roots.

To a great extent, the report attributes these difficulties to a "sleepy" faculty in this country, who lack initiative and motivation to achieve teaching excellence. "Faculty curriculum committees suffer from chronic paralysis!" charges the AAC report. They are repositories of great potential power but they are pervaded by a sense of helplessness. Above all, it continues, the claim to autonomy by departments, their power to resist unwanted change and to protect their interests, makes serving on a curriculum committee an exercise in frustration and misdirected energy. And nowhere is this inertia more apparent than in nursing education. (Actually it is probably more apparent in medicine but that's another topic.)

At this juncture of great transition in nursing and health care we need a curriculum revolution that takes a fresh look and a careful look at what society needs most in health care--what consumers need most from nursing. Then an effective curriculum committee should find itself challenging the assumptions and the foundation of our existing system and rebuilding curricula to reflect what the AAC report calls for: "powerful conflicting ideologies and political views about health care and consumers of health care in society that would seek expression in the course of study, but it would also have a constraint system that would keep the institution's curricular structure and goals from being bent out of shape by a too ready acquiescence in the ambitions of every faculty's special interests."[7] The curriculum committee, in the final analysis, should be the most intellectually exciting and challenging committee on campus.

Even if everyone could agree that there needs to be deep and abiding change made in nursing education to correspond to the changes occurring in health care and society, a spontaneous remedying of the conditions that generate lethargy in curriculum development (society's devaluation of the professorate or low wages for faculty) is unlikely to occur. The only answer lies in a responsibiity that must be placed squarely on the shoulders of our administrators, our deans, and directors of schools of nursing, our organizational leaders and presidents, to identify the curricular issues that require alteration and to shape a strategy to move their faculty to responsible action.[7] These administrators and leaders must reassert their

leadership in curricular matters in coordination and in conjunction with nursing service administrators and with consumers of health care, encourage nursing faculty to grab hold of the most critical issues facing us in health care, and to develop courses and curricula that aptly address them. As the secretary of the American Association of University Professors so aptly put it, academic leaders must help faculty transform their "Propensity to veto into an inclination to initiate."[7] If faculty and academic administrators will work as a collective to face with nursing administrators the most crucial issues that we live with on a day to day basis and the most fundamental problems that exist in the shape and complexion of health care delivery, the profession as a whole would provide a model for other disciplines and, in the end, society would be the greatest beneficiary.

We in nursing have a proud heritage of helping people in the homes, in their communities, in their places of work. We need now to have the courage to step forward together, nursing education and service, to reshape our curricula, so that students will in turn have the courage to exercise leadership in a health care delivery system that is in need of it.

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REDESIGNING NURSING EDUCATION CURRICULA TO MEET CHANGING NEEDS

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In the 1980s, it is customary to begin a speech by quoting John Naisbitt. This presentation will be no exception. I quote him as noting that we are living in the time of the parentheses--the time between eras. Says Naisbitt, "It is as though we have bracketed off the present from both the past and the future, for we are neither here nor there." A forgotten wag has said that the trouble with the future these days is, that it isn't what it used to be. I want to add to that a frequently repeated statement attributed to Adam in the Garden of Eden--"Eve," Adam said, "we are living in a time of transition." Now I have the opening for my speech--we are neither here nor there, the future isn't what it used to be, and we are in a time of transition.

Nonetheless, with the help of a distinguished panel, we are going to consider the future of nursing education. It is a daunting task, because the future isn't what it used to be; and, as the noted physicist Niels Bohr once observed, "It is hard to predict, especially the future."

For a long time women have been believed to have a special gift for foretelling the future. The Sibyls, those beautiful larger-than-life females Michaelangelo immortalized on the Sistine Chapel ceiling, were considered specialists in futuristics, and were consulted regularly by the Greeks and Romans. They practiced their prophesying at Delphi; after falling into a trance, they delivered oracular utterances in incomprehensible language, which then had to be interpreted. I don't intend to be incomprehensible, but just in case, this fine panel of specialists in nursing education will straighten me out.

The call within nursing for a future overhaul of the educational system is as old as the founding of the American nursing school itself. A recent statement by Fitzpatrick captures the point of view that echoes through 100 years of the history of nursing education in our country:

> Nurse educators must provide leadership and direction to the field in designing and deciding what patterns of nursing education are sound, appropriate, and relevant for the future. This is an important part of our educational mission, and to abdicate to any other group within or outside of nursing is to be derelict in our responsibilities." [1]

While an urgent concern for revamping our educational system runs long and deep in our history, we are not very different in that respect from other professional groups.

The Association for the Study of Higher Education this year conducted a study of the education literature in 12 professional fields, including dentistry, education, medicine, nursing, pharmacy, and social work.[2] The researchers asked: What education outcomes most concern each of these professions, as indicated by the articles in their current journals and other publications, such as professional reports and accreditation guidelines? Are there commonalities between the professions in their educational concerns? What are the differences between professional groups?

Most professional preparation outcomes are of common concern, for example, the development of conceptual competence, assuring technical competence, the integration of theory and practice, imparting ethical standards. As the study group reviewed articles in the Journal of Medical Education, Journal of Education for Social Work, Journal of Teacher Education, Nurse Educator, etc., they did, however, find some differences among the 12 professions.

Nursing ranked higher than some other professions in the emphasis placed on professional identity as an outcome of professional preparation. The authors reporting on the study observe that the fields which strongly espouse the importance of education for professional identity have two characteristics in common, namely: A short history, and the least consensus on what constitutes the body of professional knowledge and skills. In addition to nursing, education, dentistry, journalism, and social work were placed in this category, with the observation that these fields "appear to lack structured paradigms and consensus as to the appropriate knowledge and skills required for practice."

This study confirms what we know. Concern for professional identity influences our visionary and occasionally heroic rhetoric about nursing's mission and our expectations of what education should be to accomplish that mission. There is

an obvious tie here to our abiding interest in restructuring the nursing education system to achieve professional goals.

We are in a period of transition, trite though that phrase has become. The first transformation has occurred--American nursing education is now substantially in the mainstream of higher education. As we stand between here and there, are we on the brink of a second transformation? What will the new system be? Look like? Be called? We are all futurists, designing tomorrow by the choices we make today. To repeat Fitzpatrick's charge: "Nurse educators must provide leadership and direction to the field in designing and deciding what patterns of nursing education are sound, appropriate, and relevant for the future."

The question I now pose for consideration is: As futurists, shall we direct our efforts to shaping well-defined, standard educational programs, reducing the array of educational pathways, consolidating into fewer clearly identified specific program types? Or shall we nurture diversity, foster the mix-and-match approach to education, support many pathways, encourage individualization, and extol maximum flexibility? Simply stated, shall we meet changing needs by designing our educational system to be uniform or multiform? Further, is a uniform education pattern necessary to achieve our professional identity goals; that is, "structured paradigms and consensus as to the appropriate knowledge and skills required for practice"? Briefly put, is uniformity a necessary condition of unity?

With few exceptions, the weight of nursing opinion is that the future vitality of nursing rests on achieving a uniform educational structure. "Above all," asserts an ANA task force in its report, "there is a need to achieve consensus on a national system of nursing education that clarifies and standardizes the expected competencies and the educational preparation for each category of nursing practice."[3]

Many feel that because of the lack of uniformity in educational patterns in past decades, nursing has had and still has difficulty in achieving the desired impact in health services delivery. Some feel that a uniform system is needed to gain control over the distribution of students within educational programs:

> Because of the disunity that continues to exist over professional preparation of its practitioners, nursing is unable to control the number of admissions to all types of nursing programs.[4]

The argument is made that power/powerlessness in nursing's relationship with the health professions is a function of uniformity, or the lack of it, in education. According to Moloney:

> Lacking a unified system of education and a unique body of knowledge, nursing has had difficulty in joining with other health professions to influence health care.[4]

Also speaking to the effect of a lack of unity, Andreoli says:

> Lack of unity on standards of nursing education and credentials for practice has put the nursing profession in a vulnerable position. This dilemma has proved to be one of the principal reasons that nursing continues to be relatively powerless among health professions, and that the status of the profession remains equivocal.[5]

And, observes an ANA task force:

> Nursing's lack of consensus on educational requirements makes it vulnerable to the encroachments of other professions.[6]

The arguments for a <u>uniform</u> pattern in nursing education cut across program levels.

Andreoli calls for the conversion of all doctoral nursing programs to the Doctor of Science in Nursing degree. She states,

> Standardization means credentials as well as curriculum. Professional nursing will be recognized publicly by its professional degree, not in the clothing of a Ph.D. Thus, the professional doctorate in nursing must be standardized; the variations on the DSN or DNS should be eliminated. Variety may be the spice of life, but it has also been a thorn in the side of professional nursing. To the health care consumer and other health practitioners, the diversity of degrees in doctoral programs in nursing indicates that nursing cannot reach a consensus as to the nature of the scientific knowledge base of nursing, so it plays it safe and covers all bases--that is, all degrees.[5]

Williamson decries the "endless array of. . .master's programs."[7] Andreoli sums up the challenge as she sees it:

> The future of nursing education, and therefore of nursing, depends on how well nursing education reconciles its divergent goals in graduate education with the goals of the profession and the health care needs of society. . . .Most important, unity must be sought and finally achieved.[5]

Fitzpatrick calls for "assurance and evidence that there is some conformity among the baccalaureate programs."[1] Associate degree programs, she (and a number

of others) believe need to "return to their primary mission and goal" by scaling down the complexity of nursing knowledge and practice now embodied in the ADN curriculum.

In the arguments for uniformity, however, there is no agreement on what uniformity is the most desirable. Helen Grace notes:

> Doctoral programs in nursing are caught up in the cross currents of, on the one hand, preparing research and scholars and, on the other hand, maintaining ties to the clinical practice of nursing. In attempting to achieve all things within our doctoral programs, the emphasis increasingly is placed upon rote-learning of research methods and nursing theoretical frameworks, rather than upon the process of conceptualization of significant research questions and the excitement of the investigative process. Currently, no well-developed clinical doctoral program models exist.[8]

Grace argues for two distinct, and in her opinion, equally important doctoral paths--the Ph.D. research degree and a clinical professional doctoral degree. Agreeing with Grace, Amos believes that "clear identification of the distinguishing characteristics of the two degrees should provide us some direction for future program development."[9] The Ph.D. would focus on the generation of knowledge and theory, and the DNS on using knowledge to resolve clinical problems and applying research findings in practice settings.

At the baccalaureate and master's levels, there is a strong impulse in our literature toward uniformity, but a critical difference of opinion about the level at which professional practice begins.

A number of writers bluntly state that the term "professional" should be used to classify graduates of programs beyond the baccalaureate degree. Some suggest categorizing the baccalaureate program, along with the associate degree, as technical. Some advocate a pattern of a four-year general liberal arts or science baccalaureate followed by a three-year generic doctorate. In these and other discussions and debates, the direction espoused is for nursing education to press toward uniformity and definition, specifying educational routes and professional identities.

Is a case made for a multiform system of nursing education? Nursing literature yields no sizable body of argument for multiple pathways, although flexibility and diversity are cited as desirable qualities in educational patterning.

One finds the arguments that might support a position favoring a multiform system not in nursing literature per se, but in current analyses of developments, trends, and futures in American higher education. A summary of these trends and recommendations leads to some provocative thoughts about future educational patterns. Specifically, it is the changing character of the student population that compels colleges and universities to examine plans and projections in anticipation of what student goals, aspiration, ability, and motivation will be.

What trends and predictions can we discern in the larger field of higher education? The word "reform" is used by scorekeepers examining the status of higher education today. Colleges are urged, in Secretary of Education Bennett's words, to "reclaim a legacy" by bringing back the liberal arts as the centerpiece of undergraduate education. The trend in recent years toward emphasizing vocational and specialized education at the baccalaureate degree level is decried, and undergraduate curriculum-builders are called upon to generalize the educational experience, to re-establish a common core of general education for all degree-seekers. There is a new concern for applying standards--upon admission and again at graduation.

Trends and predictions of Naisbett and Tofler also have implications for uniform vis-a-vis multiform education systems. Naisbett's Megatrends prompt images of a future world which we see emerging, somewhat as the pattern of a piece of underlying cloth is seen through a thinner, nearly worn, top layer. The general direction he describes is from centralization to decentralization, from hierarchies to networking, from "either/or" to multiple option decisions. The unfolding of these end-of-the-century changes in society supports the notion that in our educational structures and organizations we should foster diversity, openness, flexibility. Similarly, Tofler's "third wave" principles include substituting individualization for standardization, and replacing synchronization (his term for lives controlled through organized routines) with self-determination.

In these trends we see a case for multiformity developing, yet the most compelling arguments for a multiform educational pattern in our future lie not in the Education Secretary's call for reform nor in the predictions and scenarios of the futurists, but in the awesomely real here and now--the demography of the population. Demographics, interestingly enough, is now called a science; it has been

added to the list of social sciences. As a matter of fact, it is said that of the social sciences, demographics is most like the science of celestial mechanics--through it we look for the higher unseen engines that make the social system work in certain ways. Let us now look at how this huge, unseen engine--the population of students who will be in our A.D., B.S., M.S., and doctoral programs in the future--might suggest an answer to the question of whether we will advocate uniform or multiform educational systems for nursing.

The demographics of education are vividly displayed in a recent report by Harold Hodgkinson. He begins by challenging our tendency to look only at our own institutional segment, whether community college, college, or university. He accuses educators, accurately I think, as inclined to look at our own educational enterprise as discrete and separate, shaped by unique factors and forces. In fact, Hodgkinson points out, education from kindergarten through graduate school is all one system, which is the title of his report. The people who are moving through at any one time make it a system and ultimately define what it is and what it is doing. He cautions all of us in education to observe the major changes occurring in birth rates and in immigrant groups that are now and will continue to dramatically shape the educational enterprise. He reminds us of the maxim that students define our programs. Hodgkinson cites these data:

1. There are substantial increases in the number of children entering the school system with backgrounds that predict major learning difficulties. These include the rapidly increasing numbers of children born out of marriage to teen-age mothers. Hodgkinson states that about 700,000 of the annual cohort of 3.3 million births are almost assured of being either educationally retarded or "difficult to teach." (He cites correlations between prematurity and low birth weight and learning disabilities.) He also reminds us that children born into poverty enter school with backgrounds associated with learning difficulty, and that the number of such children is increasing. A child under six today is six times more likely to be poor than a person over 65.

2. Asian-Americans represent 44 percent of all immigrants admitted to the United States. Asian-American youths are heavily involved in public schools; a high percentage attend college. They present a particular challenge to higher education, with understandable difficulty in verbal tasks yet higher-than-average scores in mathematical ability measures.

3. By around the year 2000, America will be a nation in which one of every three of us will be non-white. And minorities will cover a broader socioeconomic range than ever before, making simplistic treatment of their needs even less useful.

4. There is, and will continue to be, an absolute decline in the number of 18- to 24-year olds; in addition, high school retention rates are decreasing--14 percent of white students are dropping out, 24 percent of black students and 40 percent of Hispanic. At the same time there is an increase in the number of high school dropouts who acquire the GED, then seek and find a college or university that will accept them.

5. Community colleges and what he called the "blue chip" universities have experienced considerable increases in the proportion of minority students. But, observes Hodgkinson, there is a large group of institutions, public and private, that have not increased their minority populations over the last decade. Given the decline in white graduates of secondary schools that faces us until at least 1994, these institutions will have to face up to some difficult decisions. Few will close--in his words, "the legislature will serve as their heart-lung machine"--and as a result, institutions will be trying to attract anyone who is warm and breathing to their student body.

6. Hodgkinson summarizes the challenge to higher education in these words: "The rapid increase in minorities among the youth population is here to stay. We need to make a major commitment, as educators, to see that all our students in higher education have the opportunity to perform academically at a high level. There will be barriers of color, language, culture, attitude that will be greater than any we have faced before, as Spanish-speaking students are joined by those from Thailand and Vietnam. The task will be not to lower the standards, but to increase the effort. For the next 15 years at least, we will have to work harder with the limited number of young people we have to work with."[10]

This is sobering news indeed. But it is not the whole picture. Although the 18- to 24-year-old group will decline in size until 1994, there is another group available to bolster sagging college enrollments. The "baby boomers" are now in the peak middle years of earning and learning and they are the possible growth component in postsecondary education. It is these working adults, according to a recent article in The Chronicle of Higher Education, who will be attending college full- and part-time and will make up an increasing share of the enrollment in higher education--". . . the growing need for recurrent education will provide the potential for more students and dollars."[11] These working adult-students present college administrators and faculty members with new challenges that will require creativity, flexibility, and a rethinking of the traditional structures for providing adults with opportunities to renew their education and skills.

It is said that most people in the work force today will change careers three times before they retire. Many of them will, or could, become nursing students. The Chronicle also cited a recent report by the Education Commission for the States (ECS)

making recommendations to state leaders for "transforming the state role" in higher education. ECS observed that of the 12 million students enrolled in our 3,300 colleges and universities only 2 million attend full time, live on campus, and are 18 to 22 years old. Divining those celestial mechanics again, ECS expects that by 1992, half of all college students will be more than 25 years old, and 20 percent will be more than 35.

The Education Commission of the States also urges individual institutions to rethink their primary academic role and sharpen their definitions of institutional mission. In an injunction that we can take to heart in nursing, ECS observes that state and institutional leaders, "despite their best intentions,. . .tend to promote uniformity rather than diversity, and to use a single definition of institutional excellence rather than multiple definitions."[12]

It seems clear that the demography, that huge unseen engine that ultimately drives the system, is suited to a multiform system. The unprecedented diversity of students--although we in nursing are accustomed to working with diverse populations, students are becoming even more diverse--argues for a system wherein people can begin study at many different levels of academic ability and obtain the remedial, academic, and financial assistance that will allow them to succeed. Education for nursing needs to be available in negotiable units of time and in a manageable location. There is need for articulation between segments that allows the adult learner to enter, leave, and re-enter, building educational increments toward the individual's highest level of achievement, limited only by ability and personal choice.

Uniform or multiform? Is it either/or? Are the choices irreconcilable? Can we think and plan in terms of a new synthesis of uniform and multiform, creating a future system that will foster and further the profession's goals for greater leverage, autonomy, and effectiveness, and embrace the rich diversity of the student population? Is it possible to develop an educational system for nursing that embraces the order, standards of achievement, and academic integrity sought in the call for a clearly defined, uniform system yet incorporates the compelling reality and practicality embodied in the need for a multiform system? Does achieving unity in standards for our educational system necessarily result in uniformity of educational structures?

Unquestionably we need to continue to work toward definition and consensus on the unique and appropriate knowledge and skills required for nursing practice. Simultaneously we face pressing problems in our curriculum--keeping pace in clinical education with the patient acuity escalator in our shrinking hospital, responding to the inescapable urgency of committing nursing education to prepare for nursing roles in health care for the elderly, adjusting clinical education to the shifting centers of nursing practice, preparing nurse managers for emerging corporate structures, and maintaining the momentum in nursing research, to name only a few. Arching over the curricular imperatives is the larger question: Uniform or multiform?

The arresting message in the Hodgkinson monograph is in the title: All One System. Even more important than the profile of the student population is this principal idea: The segments of the educational enterprise are not separate entities, but are bound one to another by what they hold in common and ineluctably share, namely, the students. Hodgkinson states that hard as it is to believe, graduate students were at one time third-graders; so, too, in our smaller universe. Nursing graduate students were once in associate degree, diploma, or bachelor's degree programs. Increasingly, baccalaureate students were once AD or diploma students--a trend that will continue. We are all one system, with the choice of working together for the well-being of all parts of the system, or working separately and competitively to the disadvantage of all. To a large extent, efforts to professionalize nursing have, I believe, confused unity with uniformity. Unity on education standards does not require that we standardize the educational system itself. A multiform system with options, alternatives, ladders, crossovers, entrances and exits, internal and external degrees, and more, is not necessarily a system in disarray. It can be a system rich in diversity, suited uniquely to nursing skills and knowledge and to the population of neophytes which that system serves.

In a sense, I preach to the converted when I address an SCCEN meeting about cooperation and community among components of the educational system. It is precisely this that is the reason for existence of a regional compact. You have the structure for working together, the history of having done so, and the challenge of forging for this region a system for tomorrow, working in unity for a nursing education system that cherishes diversity.

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REDESIGNING NURSING EDUCATION CURRICULA TO MEET CHANGING NEEDS: IMPLICATIONS FOR DOCTORAL PROGRAMS

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Ms. Waters' comments that we are "living in a time of transition" are certainly accurate. Doctoral programs in nursing are in a period of great transition. The need for increasing the number of nurses prepared with doctorates that focus on nursing is becoming more apparent. Many schools are indicating in their recruitment announcements that the doctorate in nursing is preferred. A few years ago we welcomed a doctorate in any area.

Ms. Waters further asks the question, "Should we meet changing needs by designing our educational system to be 'uniform or multiform'?" It is my opinion that our future viability as a professional/technical occupation depends on a uniform educational structure. This holds true also of doctoral programs in nursing.

I deplore the movements to add additional levels of doctoral programs in nursing. This movement has the potential for developing as many different types of preparation at the doctoral level as we find at the undergraduate level. Nurses must decide if we will work together or if we will all work in different directions, and this is true of education at both the graduate and the undergraduate levels. I am not suggesting the need for returning to a "curriculum guide" for schools of nursing, but for a degree which can be interpreted to the general public in one paragraph rather than two pages of description of what the various degrees in nursing mean.

A colleague in a field unrelated to nursing made a very clear statement to me about the fact that nurses who are being prepared to be researchers and scholars clearly should work toward the Ph.D. in nursing and those who intend to maintain their practice in the clinical area should have a professional doctorate--the doctorate of nursing science. This was very clear to him. Why do we not find it as clear? Many times we use gobbledygook in our attempt to speak "academic lingo." For example, I spoke to the vice president of our graduate program about a generic master's program and he did not understand what I was speaking of. He had never

heard of the term "a generic master's program." I found it necessary to explain this phrase to him, and I was embarrassed.

In 1978, Florence Downs wrote about the future directions of doctoral education in nursing. The salient points that I gleaned from that article are these:

> Doctoral preparation is not and cannot be of a conventional nature, for its basic purpose is to train intellectual leaders who are skilled in the techniques of inquiry and handling of abstractions.
>
> . . .the challenge of the future of doctoral education is one which brings the resources of nursing scholars and the university into harmonious and fruitful exchange that is mutually beneficial.
>
> As more programs emerge, it is crucial that they be monitored with utmost care so that strong and quality-based programs are encouraged and that they continue to foster leaders dedicated to asking significant questions that can affect the course of nursing.

She claims that the Doctor of Education (Ed.D.) or Doctor of Public Health (D.P.H.) programs do not prepare nurses for entry-level practice. They are generic degrees. However, she indicates that the Ed.D. and the Ph.D. in Education "emerge from a common educational model, with diversification primarily evident in the dissertation and language requirements." She believes that the Doctor of Nursing Science and the Doctor of Philosophy in Nursing are also fitting within this framework; she considers it important that we make a clear distinction between these degrees.[1]

Distinctive types of doctoral programs in nursing have evolved as a result of environmental, professional, and organizational pressures. The environmental influences may be internal; for example, the formal university organizational structure. Decisions about the degree may be political. There are schools in which the nursing faculty and dean introduced the degree which could be negotiated among the various principles involved in doctoral education in the institution. Another influence is the pool of students from which the university draws. The external environment will be impacted by the political arena. This may be in the form of legislated mandates or it may be in the form of professional influences in the community.

Although we speak of uniformity, the uniformity I am speaking of is in the purpose of the degree. There is merit in diversity; this does not contradict the call

for uniformity in degrees. To establish a standard framework for a doctoral program would deny the creativity of the faculty to develop a program. This freedom also allows the structure to be tied together in such characteristics as appointment, tenure, and promotion of faculty with other disciplines within the university. This provides the opportunity for a nursing professor to be more a part of the "community of scholars" within the university. At this time in nursing's development, diversity is important. It is likely to be important for the future. Imitation among schools may occur, however, because of the difference in the governance process, in faculty, in students, and in quality, diversity will continue.

In 1984, the Division of Nursing and the American Association of Colleges of Nursing, again concerned about the present and the future of doctoral education, sponsored an invitational conference on "Doctoral Programs in Nursing: Consensus for Quality."

The purposes of the conference, as stated in the foreword by Linda K. Amos, president of the American Association of Colleges of Nursing, were "to reach consensus on issues of quality in doctoral programs in nursing, to define areas in which quality control is critical, to state criteria for assessing quality, and to identify resources and extra-university relationships crucial to the operation of such programs." Jo Eleanor Elliott, director of the Division of Nursing, supports the development of programs "with a variety of emphasis, programs that provide alternative approaches to doctoral study, and programs that focus on preparation for one degree rather than another." Elliott further states that programs "should not be developed out of need for the program alone. . .instead, they must be the natural outgrowth of more and better prepared faculty and of increased university and community learning resources, which together provide the rich environment needed to establish and successfully operate demanding educational programs."[2]

Some of my colleagues believe that the graduate level is the entry to professional practice. A study recently completed at our School of Nursing gives some indication that this may be true.[3] Others believe that the nursing doctorate is the essential educational preparation for a first professional degree.[4]

Compared with other disciplines, nursing is relatively new in the academic institution. We are in that transitional period previously experienced by other

disciplines. The results of this transition will depend on the conventional wisdom of nursing leaders--the recognition that unity of purpose must be toward the improvement of patient care regardless of the educational program. There is no place in this time of transition for vested interests. I trust that when I leave a position in an organized educational system, I will be able to look back at my contributions to nursing and know that they have been a part of a positive influence on the future of nursing and of patient care rather than being concerned primarily for my own area of interest.

Doctoral programs are in transition. In this educational program there is great need to keep up with the changes in health care delivery. The curriculum will change to meet these needs.

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REDESIGNING NURSING EDUCATION CURRICULA TO MEET CHANGING NEEDS: IMPLICATIONS FOR MASTER'S PROGRAMS

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The number of master's programs in nursing increased rapidly during the period from 1979 to 1984. McKevitt in a study of trends in master's education in nursing records a 46 percent increase over this period, listing 81 programs in 1979 and 118 in 1984.[1] Additional programs have been initiated since 1984, and there is a recommendation from the Institute of Medicine's study on nursing and nursing education:

> The federal government should expand its support of fellowships, loans, and programs at the graduate level to assist in increasing the rate of growth in the number of nurses with master's and doctoral degrees in nursing and relevant disciplines. More such nurses are needed to fill positions in administration and management of clinical services and of health care instructions in academic nursing (teaching, research and practice), and in clinical specialty practice.[2]

In examining the future, the challenge of educating nurses to meet the health care needs of the public cannot be resolved merely by increasing the supply of nurses with basic education, even though the discussion of entry into practice rages on and on. It may be alleviated by increasing the supply of nurses with advanced education if we are able to project, with some accuracy, the nature of the specific areas of need. Since the body of nursing knowledge is so great, a generalized approach to advanced practice cannot provide an in-depth knowledge of nursing. Specialization has come to be the accepted approach to the beginning level of graduate nursing education--the master's degree. Diers in an article on preparation of practitioners, clinical specialists, and clinicians, contends that specialization has gotten out of hand and whether or not it should have developed the way it has, or whether the present specialities are the right ones, is not the point. "The fact is that nursing is now entirely specialized--and thus education for practice beyond the basic is education for specialty practice."[3] Diers contends that the market place will determine which specialities survive.

Let's pretend that we are the Sibyls, those beautiful, larger-than-life females that Michaelangelo immortalized on the Sistine Chapel ceiling, and try to deliver oracular utterances that are clear, that are based on scientific prediction and that consider modern day health care market needs while still considering the escalating cost of higher education.

The question of "Uniform or multiform?" when applied to master's education in nursing is an interesting one. If one refers to the 1983 statement of the American Nurses' Association Task Force on Education for guidance, it calls for a need to achieve consensus on a national system of nursing education that standardizes the expected competencies and the educational preparation for each category of nursing. The National League for Nursing has broadly outlined the characteristics of higher education leading to the master's degree in nursing as being related to nine important areas:

1. to acquire advanced knowledge from the sciences and the humanities to support advanced nursing practice and role development;
2. to expand their knowledge of nursing theory as a basis for advanced practice;
3. to develop expertise in a specialized area of clinical nursing practice;
4. to acquire the knowledge and skills related to a functional role;
5. to require initial competence in conducting research;
6. to plan and initiate change in health in the health care system;
7. to further develop and implement leadership strategies for the betterment of health care;
8. to actively engage in collaborative relationships for the purpose of improving health care;
9. to acquire a foundation for doctoral studies.[4]

Both of these positions may lead us to believe that uniformity is sought for master's education. We need to determine if the uniformity called for is constraining nursing education in meeting the needs of society. Those who are studying various aspects of master's education and who are writing about issues call for specifics, such as mastery of clinical practice and preparation of teachers. Diers

calls for mastery in a specialized area of practice. McKevitt reports there have been some significant changes in trends in master's education that require monitoring. Recently deTornyay and Thompson noted,

> As the knowledge base for nursing has expanded tremendously, graduate programs in nursing have tended to decrease preparation in the functional area of teaching. Therefore, the teachers of nursing may well enter a teaching career with neither the prerequisite trial of competence nor the experience with the tools for teaching.[5]

These imperatives sound more inclined to call for multiform approaches. The question may be, Can we offer education that is multiform in nature without sacrificing some degree of standardization within reasonable variability?

The challenge of redesigning the curricula of master's programs to meet changing needs cannot be taken casually. There are five compelling reasons to take the subject seriously. I refer to these reasons as social cues. Indeed, they probably should be considered social imperatives. Some have political as well as social origins.

1. The Institute of Medicine (IOM) study, which was commissioned by Congress, is being used as the guideline for future federal support to nursing programs. It gives specific direction based on data collected in the 1980s and makes projections for the year 2000.

2. The market place is changing rapidly, bringing new demands to all health professionals.

3. Doctoral education in nursing makes graduate nursing education different than it was a decade ago.

4. There is concern that the escalating cost of higher education makes graduate education a privilege for few.

5. The changing demography of students prompts a re-look at who we are teaching and how to offer a quality graduate education to a changing population.

The IOM study indicates that the complexity of today's health care settings demands nurse managers who are skilled--not only in nursing but also in the techniques of managing personnel and large budgets. In addition, the quality of nurses delivering care at the bedside and in the community depends to a great extent on the capabilities of teachers who must impart theoretical and clinical knowledge necessary to produce competent professionals in a relatively short educational

period. The study states that the claim of leaders in nursing education that the current composition of the faculties of many nursing schools is inadequate to accomplish this job is probably borne out by the comments of employers as well as information comparing the preparation of nursing faculty to those of other disciplines. A closely related issue is the lack of research to inform nursing practice and to enhance nursing education. In its summary, the study points out that although well qualified generalist nurses can deliver care effectively, the growing complexity of services in many health care settings presents problems that also increasingly require the specialized knowledge and experience of nurses with advanced education.

We need only to look at the growth of multi-hospital systems developed by the private sector to realize that hospital care is big business and the market place is changing. Hospitals are faced with patients having high acuity indexes, whose length of stay is limited by the Diagnostic Related Group (DRG) system. Acute care agencies are looking for ways to maintain a respectable occupancy rate to prevent deficit spending and to keep governing boards from closing beds or, in some cases, closing whole agencies. Some hospitals have now turned to offering outpatient programs for prevention and health maintenance. In general, hospitals are having a difficult time justifying their missions after a period of too much construction.

The public, having been greatly influenced by the mass media, knows more about themselves, their families, and their health. Individuals now expect health professionals to help them stay well. Weight control and smoking clinics are popular. Exercise and nutrition are in the forefront of television specials and commercials and Dr. Tim Johnson has become a TV star. Hospitals are picking up on these missions and no longer consider care of the sick their only responsibility. Health Maintenance Organization (HMO) surgi-centers and "docs in boxes" are popular in most parts of the country. The hospice movement is no longer a movement but a permanent part of the system and has already been extended to a new class of patients suffering from AIDS.

The growing elderly population is making new demands on the system for care at home, supervised retirement living, better and more accessible skilled nursing home service, and health care at senior citizen centers. Advances in care of

premature infant care have changed the very fabric of neonatal care, heightening demand for more skilled nurses in neonatal intensive care settings, chronic care nurseries, and home care for high risk mothers and children. These are just some of the changes in the market place of the 80s that will continue for the remainder of the century. These changes require serious consideration of educators planning master's curricula. Indeed, if the curricula are not already planned to meet these needs, we as a profession are already behind the times.

Now that educators are calling for the master's experience as a base for doctoral study, should research be an expected outcome of the master's program and should a thesis be required? Should the Doctor of Nursing Science degree be a practice-oriented degree and, if so, what is the implication for the master's program? Diers postulates that "master's education in nursing is the proper place for preparing advanced nurse practitioners in specialty practice and that such education includes the development of clinical scholarship as well. Thus, master's education can be distinguished and distinct from both the bachelor's degree for entry and the doctoral concentration in research."[3] She contends that doctoral education ought to build out from advanced practice, and that students who enter doctoral study should already be advanced practitioners. Others believe that the preferred approach is to emphasize entry at the B.S. level. We are finding that service directors are coming to grips with how to utilize nurses with doctoral degrees as they carry out the research mission of nursing in practice settings. Service directors themselves are seeking doctoral education--more so than ever before.

No less important is the issue of the cost of graduate education. Traditionally, graduate study has been more expensive than undergraduate study and the gap now appears to be widening. Gunne reports that when budget problems arise, the negative impact may be felt at some degree levels more than others.[6] Of 108 schools responding to a study on fiscal status of nursing education programs in the United States, 73 (68 percent) said the effects were felt primarily in their baccalaureate programs. Continuing education units were second hardest hit with a 9 to 10 percent cut, followed by the master's programs at 7 to 8 percent reduction. There are widespread similarities in the budgets of nursing schools, and most administrators agree that budgeting has become more difficult but that nursing programs are weathering a salary storm. According to Gunne's study, there is little,

if any, real financial exigency among reporting institutions with 94 percent of the schools indicating that they continue to receive their fair share of the instructional budget. Gunne's study I believe may be unduly optimistic; it is difficult to accept when 6 percent of the reporting schools are not getting their fair share and at least 300 schools did not answer the survey.

The IOM study states that in times of severe economic constraints, states may be more willing to finance basic nursing education programs that are perceived as directly fulfilling local demand for nurses than master's programs, whose graduates can be expected to be more mobile. The study report suggests that joint programs with other university departments, such as business and health services administration, be pursued and states that financial assistance to nurses in master's programs should be packaged with federal funds for programmatic supports. The study also spells out the need for master's programs to seek competitive funds from agencies for research and training. Graduate programs in both private and public institutions must realize that institutional funds alone cannot be expected to sustain quality programs over time. It is not unreasonable to expect that in the 1990s institutional support will be one-third from within, one-third from research grants, and one-third from philanthropic donations. Complacency regarding financing graduate education in nursing will lead us to mediocrity rather than excellence.

Last but not least is an unabiding concern over the nature of the pool of students available to study advanced nursing practice. The Washington Post reported in August of 1986 that according to The College Board, the average SAT score in 1985 of students intending to be registered nurses was 328 in the verbal part of the exam and 361 in math--a total of 689.[7] That is 217 points below the national average, compared with a gap of 177 points in 1977. Recruiters report that high school students are more interested in the professions of law, medicine, and pharmacy. Admission committees see the better qualified students seeking the higher paying and more prestigious careers.

The mean age of nursing students in undergraduate study is rising, which means the graduate student is even older than in the 1950s and 1960s when graduate education in nursing became popular. More men and minorities are considering nursing and some who fail to find employment after a liberal arts education seek a professional degree hoping to find satisfactory career opportunities. Nursing

students tend to come from lower and middle class income families who are finding their family finances more and more difficult to stretch each year as the American class system changes and tax laws have an impact on education.

Those of us who dare to redesign master's curricula will not do so without criticism and extra special effort. However, if we take the path of least resistance, live with the status quo, and ignore the social and education cues, graduate programs in nursing will fail to produce the caliber of advanced practitioners, teachers, administrators, and researchers who can meet the challenge of the 21st century. Most of today's students will be managing the profession in the next century.

The IOM study, which, by the way, has a political position on the needs of nursing, has not gone far enough in its educational recommendations. While it describes things as they are and makes some projections for service and education, by and large it is not aggressive in its educational recommendations for graduate education. That opinion was shared by two of the panel members who filed a minority report.

It is my opinion that nurses in all roles have for many years been taught to be change agents. The health care system has seen so much change so fast that I believe we must now teach all students to analyze the systems around them--the patient care system, the personnel system, the financial system, and the political system. They should be taught to understand the system, work with the system, try to make the system work, before making decisions to change it. Perhaps this is a call for openness, a willingness to tolerate a multiform approach to making the system work.

I make the same appeal when considering the market place. I am not suggesting that nursing should be missing from the entrepreneurs of the 21st century, but I plea for graduate education to help them understand what is going on. Only then can we teach, practice, manage, and conduct research in a modern society.

We are well on our way to establishing the discipline of nursing in doctoral education. Although educators have recently set forth a set of quality indicators for doctoral study, those indicators should in no way constrain intellectual freedom, nor

inhibit scholars from setting new horizons in research and practice. Again, it is a call for multiformity in the profession, yet with a hope for understanding and explaining the nature of nursing to the world once and for all.

I don't believe that we should try to do all of those things with a cost containment mentality. Nursing has never had its fair share of the financial pie; we have never operated in grandeur either in the educational nor the service setting. The reality may be that there is less money available through traditional sources, but we must develop a multiform approach to financing graduate education. Instructional resources and student tuition and fees will always be a primary source of revenue, but tuition will have to eventually be capped or education will be too expensive for all. Extramural research support is available in both the private and public sectors; we need to be more competitive for our piece of that pie. And then there is philanthropy. Yes, the tax reform law will make some private donors think twice about gifts without benefit of tax credits but there are other ways to give that build estates and develop tax shelters. We need to find those approaches and work with university development and foundations offices to make better use of less traditional opportunities. Our new horizon for revenues is through patient care fees. In the 21st century our practitioners will succeed in this area and educators must work now to put practice plans in place that will enhance the revenue base for faculty in schools of nursing. The midwives and the nurse anesthetists have won the reimbursement issue; other nurse practitioners and clinicians are not far behind.

New teaching techniques must be tried to respond to our changing student population. Outreach programs and career ladder programs will work for the adult learner. Specialized programs will work for disadvantaged students. Independent learning will work for the bright students; humane, sensitive, and caring educational approaches are required for all. Graduate students must be treated like colleagues. Faculty must act with them, not on them, and above all we must attract the bright to graduate study. There is only room for those with high potential at the graduate level. This is the level that sorts the women from the girls, the men from the boys. We need to be right about our selection process. If we are, we will have no apology for being elitist at this level of professional education, and we will be on our way to preparing outstanding leaders for the profession.

There are risks in all that we do to educate nurses. There is a risk in redesigning curriculum for fear that the redesign is not perfect, but there is more risk in clinging to the status quo and risking obsolescence.

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REDESIGNING NURSING EDUCATION CURRICULA TO MEET CHANGING NEEDS: IMPLICATIONS FOR BACHELOR'S PROGRAMS

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Since its inception in the early 1900s, baccalaureate nursing education has traveled a long, laborious road although in many respects a highly successful one. With the opening of the 20th century, no one could have predicted that the American system of higher education would expand so dramatically and become as diverse and complex as we know it just before the beginning of the 21st century. Not even in their wildest imagination could early nursing leaders have forecast that the public could afford, acquire, and consume the amount of higher education that has now become a reality. Two forces were ready to move at the right time: (1) nursing was established in higher education; and (2) higher education was ready to expand with unprecedented growth patterns. Where did those nursing leaders acquire their vision? Where will we achieve ours?

Perhaps by looking at the current societal climate and describing some of the present context in which baccalaureate nursing education finds itself, we will find a point of departure for future nursing education. Many issues and trends are impacting on baccalaureate nursing education. In addition to the growing dialogue and literature from all sectors of society reflecting shifting trends, members of the nursing profession are identifying concerns and issues that they feel the profession should address to remain viable in future years.

Our organizations have taken positions, or at least postures, on many practice issues such as (1) two levels of entry into practice; (2) changes in licensing and credentialing; (3) movement of patients/clients from the hospital to the community; and (4) expanded roles for practice.

An equal number of issues in nursing education are evidenced in the literature. Some of these include: (1) increased push for cooperative educational endeavors; (2) articulated curricula; (3) faculty practice plans; (4) collaborative and/or unified models for nursing service and nursing education.

As we look at redesigning the curricula to meet changing needs within society, some very difficult challenges lie ahead. To synthesize the observed and forecasted changes, some factors must be stated about the realities of current baccalaureate nursing education.

1. Many baccalaureate nursing designs are in operation, for example, a generic four-year curriculum, two plus two curriculum, advanced placement only curriculum, integrated curriculum, block curriculum, etc.

2. Basic beginning academic knowledge and skills have not been acquired by a number of persons applying for admission to baccalaureate nursing programs.

3. Qualified faculty and competitive faculty recruitment are almost nonexistent in a number of institutions.

4. In some instances, senior and well-qualified faculty are recruited for employment by other sectors of the profession, for example, master and doctoral programs, educational administration, nursing service, research projects, consultation positions, etc. The dearth of senior faculty members means there are few mentors for new faculty.

5. Expected professional competencies have not been apparent in many baccalaureate nursing graduates.

6. There is a high degree of diversity in the settings where baccalaureate nursing education resides. This is conducive to wide variances in the implementation of baccalaureate nursing curricula in, for example, rural versus urban settings, medical centers versus general purpose universities, and public versus private institutions.

7. Student enrollment has decreased.

8. Many programs are operating under severe economic constraints.

With some of these limiting factors stated, let us move forward with a more optimistic approach. What decisions need to be made at this time? Perhaps a start would be, what should baccalaureate nursing education retain, negotiate, and relinquish?

What should be retained? Above all, nursing education in the mainstream of higher education should be retained. Seems like a simplistic statement but it has not always been too easy to achieve. Nursing has built its practice on the foundation of general education requirements. These requirements are essential for a professional level of practice as well as forming the base for all advanced education.

Evolving from nursing taking its place in the mainstream of higher education has been the development of nursing theory, the utilization of nursing concepts, and the demonstration of these in nursing practice. This progress has been achieved mainly in the past two decades. This progress should be guarded, further development pursued, and new areas identified with changing and expanding practice.

Now for some points of negotiation. The number of years spent in a baccalaureate nursing education program is not sacred. However, the number of hours and quality in the upper-division nursing courses is. If redesigning of curricula to facilitate mobility for other types of nursing education occurs, then particular emphasis and attention must be given to the upper-division nursing courses so they retain heavy emphasis on the professionalism of the nurse, depth in practice, knowledge of management, and research.

Another area begging for new approaches, not necessarily the curriculum design per se but bound to it, is the area of student recruitment. It has not always been honest. That is the bottom line without any other comment. Dishonest recruitment has precipitated a number of problems the profession is facing today.

Some areas very definitely open for negotiating are entry routes, progression, and some areas of licensing and credentialing. Other decisions need to relate to the number and geographic distribution of programs that are required for a well-functioning nursing education system or network.

Since most of us present were educated in some type of baccalaureate nursing program, you may want to be more emotionally involved in what baccalaureate nursing education can relinquish. Ms. Waters presented convincing documentation that we will be living in a more diverse society. Hence, the belief that the present basic generic baccalaureate nursing education can only exist in its present form appears to be a notion we are challenged to give up. The potency of this form of education is diminishing now to some extent and, based on the facts today, if it were to exist it would serve a rather narrow segment of society.

Another challenging area is found in the multiple curriculum designs that exist. I am a supporter of multiplicity and options, so I want some variation in continuing programs. However, many of the existing curricula show muddled

thinking in the actual curriculum plan and the expected outcomes of the graduates. In many cases, curricula have been designed to meet the institution's need or those of one or two faculty members rather than to meet a student's educational needs or a client's health care needs. Therefore, many existing curricula plans could be relinquished.

Regardless of the "airs we put on" about baccalaureate nursing curricula being the traditional repository for community health nursing courses, the truth remains that there is a dearth of qualified community health nurses--to teach or to work in agencies in many communities. This may be seriously influenced by the fact that the nursing curricula in a large number of colleges and universities are weighted heavily toward hospital settings. We need to let go of our heavy preoccupation with hospital-based education.

Now, changing focus, let us look at what the faculty of one program have done in response to some of the societal occurrences described by Ms. Waters. In the past three years courses have been changed, with some of the new required nursing courses being economics, political science, pathophysiology, and a nursing elective. Health assessment has been made a separate course with the hope it will be a better foundation for professional practice. Professional nursing development courses will be offered during each year of the curriculum. The focus of the courses will be on current issues and trends. Many other things could be mentioned.

Basically, change may occur because individuals or a collective group of people exert enormous influence. Where do we expect to find this leadership? It will come from our present colleges, universities, and professional organizations.

An example of a group coming forward is the American Association of Colleges of Nursing (AACN). In the new document, Essentials of College and University Education for Nursing,[1] some basic assumptions to direct future nursing education are set forth. The report is well written and, at the baccalaureate level, has deep implications for improving the quality of an individual's education as well as care given to the public. The three areas which, according to AACN, must be incorporated in future education are: (1) liberal education, (2) values and professional behaviors, and (3) professional knowledge and practice. The document supports each of these areas well and places considerable emphasis on the

socialization process of the student entering the profession. Some of this document would provide an excellent foundation for future baccalaureate nursing curriculum design.

In concluding, let us reflect on the marvelous century this has been for nursing education and particularly baccalaureate nursing education. Will we as nursing educators be able to leave such a legacy for those viewing nursing education at the end of the 21st century?

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SHIFTING PATTERNS OF NURSING PRACTICE: IMPACT ON ASSOCIATE DEGREE NURSING EDUCATION

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> Dear, dear! How queer everything is today! And yesterday things went on just as usual, I wonder if I've changed in the night? Let me think: Was I the same when I got up this morning?

If you have read Lewis Carroll's Alice in Wonderland, you recognize Alice's predicament and can liken it to the situation we as nurse educators find ourselves in with shifting patterns of nursing practice. I will focus on four patterns affecting nursing practice as they relate to associate degree nursing education.

Pattern 1: An Increasing Aging Population with Commensurate Greater Needs for Health Care Services.

The first pattern is significant for both the nursing profession and the public. According to Harrington, reporting Census Bureau data: "We (the United States) are aging at a rapid rate. The proportion of the population 65 and older has increased from 4.4 percent in 1900 to 11.3 percent in 1980, with a projected additional increase of 27.7 percent (to 13.3 percent of the total population) by the year 2000. With the turn of the century, 35 million of us will be 65 and older."[1] Experts project by the turn of the century the population 75 years and upward, the "old-old," will constitute 6.5 percent of the population.

The expanding proportion of the elderly places an added strain on a health care system already overburdened. Little change has occurred in comprehensive care for the elderly. If they become sick, they are placed in hospitals where the latest technical advances are available. Frequently, if the disease cannot be cured, then the elderly are placed in long-term facilities. Furthermore, the elderly have a higher proportion of chronic diseases and health care problems, disabling conditions and a greater need for personal care services--not to mention medical and nursing service needs. Harrington reports that, "The aged represented only 11.3 percent of the total population in 1980, but accounted for 31 percent of the total health care expenditures. Per capita health care spending for the elderly accounted for 3.5 times greater costs."[1]

Social cultural changes are occurring which affect the delivery of health care for the elderly. We are a mobile population. The family unit is undergoing restructuring. Single parent families are common. Women are entering the work force in record numbers, with more than 50 percent single, widowed, divorced, or separated. There is a declining birth rate. Since fewer of us are at home to provide informal services for the elderly, we increasingly depend on an array of formal services.

Who are the clients entering long-term care facilities? Fisk points out, "Most are women over 75 years, with 80 percent being widows. They average at least four chronic health problems; many are on regular medications, have serious limitations in mobility; and some have a decrease in cognitive function."[2]

The problem is further compounded by the complex situation of trying to obtain services for the elderly that are affordable, effective, and safe. The shortages of some services are acute--meals, adult day care centers, transportation, homemakers' services, and congregate living, hospice, and long-term facilities.

Examining long-term facilities further highlights the seriousness of the situation. The number of nursing home beds has increased (by 73 percent from 1969 to 1980) yet the expansion has not begun to keep pace with the increasing demand of an aging population. Admission to a nursing home often implies months on a waiting list. Eligibility, as spelled out by Medicare, is often restrictive in terms of coverage, length of stay, and available services. All too often the individual and/or involved family have depleted their financial resources, not to mention having endured psychological stress. Services are frequently inadequate and unsafe, or barely cover the complex needs. One has only to read the newspapers to know quality of care is a major concern; abuses are well-documented. The fragmented, non-comprehensive care does not enhance the elderly's potential for rehabilitation. Many elderly desire and have potential to continue to be productive, contributing members of society.

The situation is challenging and far from desirable from the prospective of nursing. Few nurses have had special education in gerontology. Professionals bring to the work relationship many prejudices about the elderly. Mezey points out that "Work with geriatric patients and in long-term facilities are consistently cited as

the least desirable speciality by nursing students. Less that 5 percent of the (nursing) students express a commitment to work with the elderly despite identified needs. . . . Yet, the reality of nursing is they will most likely be involved in some aspect of nursing care with the elderly during their nursing carrer."[3]

The American Nurses' Association reported that only 14 percent of the nursing programs included specific geriatric content and learning experiences in the curriculum. A 1981 survey of 43 programs in North Carolina revealed only 22 were using nursing homes for beginning students and 11 were using them for advanced clinical experience.[4] Daria & Moran state that "by 1990, the need for gerontologic nurses will increase by 400 percent" with most of the nurses needed outside the hospital.[5] Many state boards of nursing are considering requiring a minimum number of hours in geriatric nursing content and learning experiences for entry-level nursing programs. This would ensure that nurse educators address the health care needs of the elderly.

Furthermore, "within the next five years, at least 50 percent of hospitals nationwide will develop or contract home health care service," predicts the president of The National Association for Home Care. Of the 3,281 hopsitals responding to the recently released survey by the American Hospital Association, one-third now offer skilled nursing services or home health. Some predict that hospitals of the future will have two roles--one as a high tech center primarily for the 65 and under and also as a diagnostic/treatment center for those over 65. Hospitals are becoming a three-tiered structure of acute care, skilled nursing or intermediate care, and programs to sustain the elderly's independent living.

From an associate degree educator's viewpoint, addressing the health care needs of the elderly is complex. Long-term facilities are not always seen as desirable for student learning. Faculty are less than enthusiastic; they and students see fragmented care, limited resources, large numbers of unlicensed personnel, understaffed units, and few rewards or incentives for future employment. The challenge to provide comprehensive, safe, humanistic care to the elderly is substantial. What does all this mean for associate degree nursing? Future forecasts point to:

Expansion of health care services for the elderly, which constitutes the age group "65 and 75 plus."

Increased demand for skilled nursing care both in hospitals and ambulatory centers.

State boards of nursing examining and mandating specific types of geriatric content and learning experiences if nurse educators do not address the issues adequately and prepare graduates for this practice area.

Expansion of the job market in long-term facilities with commensurate contraction of hospital settings for A.D.N. graduates.

The majority of nurses being involved in some aspects of health care for the elderly throughout their professional careers.

A short supply of faculty prepared in gerontology will continue for at least the next decade.

Pattern 2: Health Care Cost Containment and Its Impact on Health Care Delivery.

The nation's health care system is undergoing revolutionary restructuring and warrants careful examination. Since 1965, according to Grier, the cost of health care, after adjustment for inflation, has doubled to $350 billion a year.[6] Further, 33 million Americans in 1983 had no medical insurance. Lancaster reports an additional 15 million having inadequate coverage.[7] In part, this may be due to such economic factors as job loss and accompanying loss of health benefits. In fact, in the June 20, 1986 issue of the American Medical News it was reported that the lack of access to health care is the number one health care problem in the United States today.[8] "Currently, health care is 11 percent of the Gross National Product (G.N.P.) and projected to increase to 12 percent by 1990."[9] Moreover, "Health care constitutes the fourth largest item in the federal budget which is equivalent to $1 billion per day. Compounding the problem is the fact that Medicare costs are doubling every four years at a rate 60 percent higher than collected earmarked payroll taxes.[6]

In 1984, the Health Care Financing Administration (HCFA) released a report that cited 48 percent of hospitals as being deeply in debt. Most often those in trouble were in small rural locations--a major place of practice for A.D.N. students.[10] From 1980-1984, according to Schull, 270 hospitals closed their doors.[11] Bronson reports that last year, 49 hospitals went out of business, with 70,000 workers losing their jobs. Furthermore, in the past three years, hospital occupancy rates have fallen to 63.3 percent. Some rural hospitals report even lower rates. Hospital in-patient length of stay has decreased to 6.7 days.[12]

However, the American Hospital Association statistics show out-patient visits had swelled by 11 million in 1985 for a total of 245 million. The major reasons

cited for the shift in services are the DRGs cost containment initiatives, and business and insurance reimbursement strategies. If the trend toward hospital closures, decreasing in-patient admissions and length of stay in hospitals, and increased use of ambulatory services continues, the next 10 years could see 500 fewer hospitals, 20 percent fewer hospital beds, increasing acuity level of clients, and perhaps one million less hospital jobs.

Davis observes that "hospitals with the greatest chance of survival will be those who focus on quality nursing care because that is what attracts patients." Furthermore, the former HCFA administrator notes, "nurses bring to health care that one attribute it cannot do without--simple human caring."[13]

With the restructuring of the health care system, hospital nurses are likely to see increased acuity levels in speciality areas with a commensurate decline in old general medical surgical units. Daily patient loads will increase with nursing departments moving to a more decentralized structure. Team nursing will fade; primary nursing will be the model of organizing nursing care. Higher quality care will be expected from fewer employees. We know hospitals are becoming one large intensive care unit. Increasing acuity levels will also be visible in post-hospitalized clients due to early discharge and continued post-convalescence problems. Thus, the nurse's role is being restructured to deal with more complex problems. This means a higher level of decision making and professional competency.

What does all this mean for associate degree nursing? Future forecasts point to:

An alteration in the traditional health care delivery. This is due to a federally mandated cost reimbursement system producing a greater demand for highly skilled practitioners and decision-makers.

Hospitals continuing to examine costs and offering only those services that are profitable. Hospitals will continue to expand in the community to ensure a feeder system for survival.

Consumers and employers expecting quality health care at affordable prices.

Hospital admissions representing increased acuity levels of specialized care.

Ambulatory services continuing to expand at an alarming rate providing diversified services for all population groups.

Contractural arrangements replacing referral patterns for health care services.

Most hospitals becoming part of a multi-hospital system.

Out-patient health care becoming regulated like in-patient health care.

Continuing conservative federal fiscal health care policies.

Major hospital corporations uniting with businesses and insurers for power, as well as for cost effectiveness, survival, and political clout. In turn they will be able to offer an array of services.

Businesses continuing to encroach in health care reimbursement as a way to control costs.

The majority of nurses being employed outside the hospital setting in the next decade.

An increased need by health care professionals to incorporate cost containment factors in their daily nursing practice.

Nursing costing out its services as a way to be cost effective and ensure viability.

Pattern 3: Advances in Science and Technology That Are Restructuring Nursing Practice.

Advances in technology are having a dramatic impact on health care delivery--especially the nurses' role. Christman contends that the "amount of science and technology is doubling every two years with obsolescence occurring at an alarming rate."[14] He projects that "within the next decade there should be 32 times the amount of science and technology available." What a challenging thought to grapple with and for which to prepare associate degree nursing graduates.

For example, advances in computer technology can be frightening and require a good deal of sophisticated skills and decision making. Stephens purports that computers are changing the nursing practice area in three ways: "(1) Machines which regulate themselves; (2) machines for non-invasive therapies; and (3) machines which have increased the demands on the nurse in skills and decision making."[15] Obviously, computers are now a part of our everyday professional lives. In fact, nurses unable to interface with computers have limited productivity in many clinical settings. By 1990, it is projected that most hospital nursing stations will have a computer and in many settings one will also be in the client's room. The most rigorous application of computer-assisted care will be in the intensive care areas, where sophisticated monitoring will deal with the health compromising complications that require immediate responses.

In the not too distant future, we will probably see hospitals that serve as high tech hubs with webs of telemetry radiating outward to rural settings. These computer/communication networks will provide diagnostic assessments, monitor

health care problems, and provide a host of data for families and/or rural professionals. Could it be that care will return to the home, where it predominated at the turn of the century? The home may become an additional high-tech center of the future. Many of the sophisticated technologies will pose moral and ethical dilemmas inherent in their use. Who will have access? Who will pay the bill in a cost-containment era? Are the bio-technical devices socially acceptable? We will need guidelines for working with technology. Technology will promote a new way of thinking, not just the operation of equipment. While the public is aware of the highly visible technologies, such as artificial hearts, the most profound impact may come from advances in less invasive surgical technologies which will broaden the scope of ambulatory health care delivery. I am talking about implant devices like heart regulators and insulin pumps. These devices will allow clients to live outside the hospital setting and make it possible for the residential community to become a primary site of health care delivery.

On the other hand, Naisbett believes that high technology is not self-promoting, but promotes a greater need to be with people. He contends that "for each advance in technology there must be a counterbalanced need for human resources."[16] Nursing is based on human care--personalized care. What better way to capitalize on the increasing value of nurses than couple high tech with high touch. Probably, the high touch trend blended with advances in technology will change nursing practice settings from predominately large tertiary and secondary institutions to small primary institutions and the home. Who else but the nurse focuses on the total individual and at the same time is prepared as a highly skilled practitioner? I agree that technological advances will continue to require more technological assessment skills by nurses. Furthermore, nurses will need to make subtle and highly sophisticated judgments about client conditions based on technological equipment. But one must not forget that it is an individual who is hooked up to the monitor and wires--a person who has feelings.

What does this mean for associate degree nursing? Future forecasts point to:

Continued advances in non-invasive and invasive equipment will spread at a rapid rate to ambulatory as well as tertiary care settings.

Expansion of computerization and communication networks will radically alter nursing practice.

A labor-intensive health care system will mean that only the competent practitioners will be hired and survive.

Treatment costs will escalate due to complex technology.

Pattern 4: Health Promotion and Changing Life Style.

Today, life is lived in the fast lane but individuals increasingly also want to be in control of their lives. Americans are becoming more involved in self-care activities to prevent and/or retard disease while enhancing our health. A healthy life style is a high priority, as evidenced by data showing that 70 million or approximately half of adult Americans are engaged in some type of health care activity.[7]

A 1985 National Center of Health Statistics survey of 18,300 American households, which was designed to monitor health promotion and disease prevention, revealed some interesting data:

> (a) 55 percent of adults now eat breakfast, (b) 55 percent of women have annual breast examinations and 45 percent have pap smears, (c) 40 percent of adults have smoke detectors in their homes, (d) 74 percent of adults have annual blood pressure checks, and (e) 42 percent of adults exercise regularly.[17]

The type of health promotion activites we most often pursue include stress management, blood pressure control, nutritional improvement, weight loss, substance abuse control and counseling, meaningful work, leisure time activities, and physical fitness. Most importantly, to meet individual needs, consumers want an array of health care activities and services to select from. In fact, as a nation we are so focused on health that we spend $25 billion annually on fraudulent health care clinics, pills, and treatments--all in the pursuit of a better life.

We are becoming a population that wants direct involvement in health care education programs.[6] In fact, health programs are expected to flourish in schools, at the work site, and in the home. More health fitness centers will open and expand their services.

Furthermore, health care programs will reach out to all age agroups. What better place to promote health care education than in elementary schools. Healthy life styles established early in life increase the probability of a future healthy population while reducing health care cost to an already over-burdened system.

Andreoli and Musser cite Igoe's 1980 research where "70 percent of the 1,000 school superintendents surveyed believed that health care educational programs and services should be expanded."[6] Moreover, with an estimated 101 million workers, the work environment is an excellent place for health assessment and services for high risk groups. In fact, as employers read the balance sheets, the evidence is clear. Health promotion programs are a capital investment which will generate increased worker productivity and, in the long run, lower a company's health care costs.

As adults "retire" from the work place, health care continues to be a primary focus. The elderly desire health education programs as a way to enjoy life and be productive. What better way to deter the onset of chronic, debilitating disease?

In the final analysis, we are realizing that we are responsible for our own health, life style, and environment. Unhealthy habits can be altered. The rewards are a better quality of life that reduces the chances of life-threatening health care problems.

Nursing has always supported and been involved in health promotion. Unfortunately, in many settings, third-party payers do not reimburse health promotion or education provided by nurses. The changes in life style clearly point to new areas of employment for nurses--spas and diet centers for example. Possibly the nurse will become employed in a business setting and will be able to focus on prevention and fitness care rather than emergency duty. We need to emphasize a healthy life style by having students entering nursing focus on a healthy life style for themselves. How else can they serve as a role model that says "I, too, value my health as well as yours." This is an area in which nursing should continue to focus and provide valuable service.

What does this mean for associate degree nursing? Future forecoasts point to:

The public will continue to be more responsible for its health.

The nurse's role will expand and become more important in health promotion and education in all practice settings and with all population groups.

Based on these four patterns and concomitant forecasts, I would like to conclude with some strategies for you to consider in your respective educational setting:

1. Throughout the curriculum students should be provided with content and clinical learning experiences in long-term facilities as well as hospital settings to ensure that the needs of the elderly are addressed. We need to highlight all aspects of caring for the aged since associate degree graduates will increasingly work with this population.
2. Since faculty members with specialized training in gerontology are in short supply, we need to make a special effort to provide educational opportunities for faculty.
3. A clarification of values should be incorporated into the first nursing course so students and faculty alike can begin the process of sorting and clarifying values related to the elderly and to changes in clinical practice.
4. No matter the educational level, faculty and students must understand health care economics and cost factors and recognize their significance in daily nursing practice.
5. Graduates must be highly skilled technicians. Probably we will need to increase the amount of time in a simulated laboratory setting to ensure self-confidence and increase proficiency in the clinical area. Students will have to have a basic understanding of frequently used technological equipment, such as non-invasive and invasive monitor devices and life sustaining machines. Clinical rotations to critical care and emergency rooms may need to become part of the curriculum as a way to emphasize critical skills. Possibly operating room experience should be included to reinforce aseptic technique and prepare for future employment opportunities. Also, rehabilitation units should be included in clinical rotations. At all times, students should not lose sight of the humanistic aspect of client care.
6. Communication skills are going to be more important than ever in dealing with documentation and data processing systems. Graduates must be able to relate therapeutically to clients attached to high tech equipment.
7. Due to the increasing complexity of the health care system, perhaps students should be oriented to what to do for clients under "ideal circumstances with maximum resources" and then eased into "less than ideal situations." This should make it easier to understand financial considerations and enhance clinical problem-solving skills and resourcefulness.
8. Faculty's clinical skills will have to be evaluated and opportunities provided to upgrade their ability to use high technology through joint appointments, weekend/summer employment opportunities, workshops, and in-service programs in clinical agencies.
9. We must ensure graduates are up to date by incorporating computerization in the curriculum; faculty may need orientation as well.

10. The nursing process needs to be well established as part of graduates' experience, with emphasis on assessment skills, discharge planning, teaching self-care activities, interpersonal skills, technical competencies, and most importantly, caring approaches.

11. At the outset, healthy life styles for nursing students should be emphasized. Learning experiences might address good nutrition, stress management, physical fitness, and psychological support strategies. By helping students focus on themselves, they will develop a greater appreciation for health and increase their self-esteem.

12. Focus on what associate degree nursing graduates do well and tell everyone about our graduates' contributions to health care delivery. We are proud of them; they are valuable; they do make a difference.

In closing, I want to remind you that Alice in Alice in Wonderland realized the world is different and at times feels queer. Yet, Alice always kept her eyes directed toward her goal: getting home. Today, in a topsy-turvey health care world, we too must keep our eyes on the shifting patterns of nursing practice. As nurse educators, we must serve as role models and develop uniform or multiform strategies to ensure that our graduates are up to date, competent, caring, competitive, and valued members in the health care system.

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THEORY-BASED NURSING--THE FOUNDATION FOR PRACTICE AND EDUCATION: A NURSE ADMINISTRATOR'S VIEW

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Expansion and diversification in our health care organizations place increasing demands on nursing administrators to design, develop, and coordinate nursing services to achieve a cost-effective nursing product for patient populations. What common organizing principle helps us with our planning to obtain nursing results and justify the use of our nursing resources--the types and numbers of nursing personnel needed? In my view, nursing executives need a clear, consistent, comprehensive guide for this purpose--a valid and reliable theory of nursing. (From a service perspective, a theory is valid if it is representative of the real world of nursing.) Theory should provide the substantive structure upon which we "hang our hats" and be the foundation for the development of nursing practice and the practitioners of nursing.

I realize that there is no common agreement among us about the validity and utility of any one theory of nursing. Our perspectives differ, but it is hoped that each will respect the other's point of view as every one of us has different responsibilities in nursing. The point of common agreement is that each of us, in his or her own way, is striving for improvement and the continuing development of nursing.

As an employer, I find that most nurses hired by our agency have no clear concept of nursing upon which to base their practice nor are they able to identify specific nursing results to be achieved through their efforts. Inasmuch as our rehabilitation hospital provides a variety of inpatient and outpatient services for disabled persons, a common conceptual nursing framework is needed as the basis for operation, to articulate and coordinate nursing effort.

On the inpatient service, the three levels of care include a constant care unit for more acutely ill patients, the regular inpatient units, and a self-care unit in which rehab patients under nursing supervision begin independent living programs with or without a caregiver. On an outpatient basis, we have comprehensive outpatient rehabilitation facilities (CORFs), the usual hospital clinics, and home

health. Our home health department, the only hospital-based program in the area, provides not only general and rehabilitation nursing services but psychiatric-mental health nursing as well. More recently we have initiated high technology services--intravenous therapy, hyperalimentation, etc.--in the home to meet the needs of the more acutely ill.

A new organizational development in our not-for-profit hospital has been the formation of a for-profit subsidiary. Its purpose is to offer rehabilitation management services to other hospitals that are planning to open rehab units. Nursing management, policies, procedures, documentation tools, and training in rehabilitation nursing are provided through this program. All of these services and programs offer opportunities and challenges for nursing and our nurses.

Given this range of services, how are the nurses meeting the chllenges in practice today? Five questions were posed for me to answer:

1. What decisions were made about the nurses you employ?
2. What do you expect from the various types of graduates?
3. What do you find?
4. If you hire the full spectrum of nurses, why? And, corollary to that, is there a job differentiation for different graduates?
5. And, why did you choose the model of practice you use?

1. Decisions Made.

Pragmatically, decisions made to hire nurses are based on available supply. It takes time to selectively choose and educate nurses to fulfill the roles and functions required by an organization. Most nursing executives accept the fact that they have to train and develop nurses to meet the agency's needs. I strongly urge able members of our staff to seek further formal education in nursing at a level appropriate to the individual. For this purpose our hospital has an educational assistance program. We believe formal education not only enhances nurses' careers, it gives them new perspectives on nursing and makes them more productive workers for us and for our patients.

We prefer to hire baccalaureate graduates because of their broader base of knowledge, especially in community health, in leadership, and in interpersonal

skills--all of which are assets in working with disabled persons. Nevertheless, we employ all levels of nursing workers on our nursing team--vocational, technical-technological, and professional at both beginning and advanced levels. The cost resulting from the numbers of workers needed for intensive rehabilitation necessitates the use of less expensive technical and vocational personnel. How effectively they are used is the question.

A model of the nursing process, adapted from the work of Dorothea Orem,[1] is used to show how the roles and functions of different levels of nursing personnel are differentiated and related (see Figure 1). These roles and functions have been incorporated into our job descriptions. This model serves as the basis for my discussion of our expectations and findings about nurses today.

2. Expectations.

The following expectations are based upon what our nurse managers currently perceive about the functioning of registered nurses. They do not include our thinking about what should be in the future.

1. Graduates of all work-preparatory education programs will have knowledge foundational to nursing. This includes the scientific principles and basic skills needed to perform at their level of educational preparation and a basic understanding of the professional, legal, and ethical requirements of the occupation. In contrast to experienced nurses, newly graduated nurses will lack competence and confidence in themselves. The exception to this will be nurses who have gone through a summer externship program in which they have had several months of practice under the guidance of RN preceptors.

2. Few nurses, if any, will have knowledge or experience in rehabilitation nursing. It will take at least one year for either a new or an experienced nurse to function comfortably or effectively in our situation.

3. All nurses are expected to have sufficient interest in and responsibility for seeking information as needed to improve their knowledge and skills.

4. All nurses will work flexibly within the organizational framework to meet patient and service needs.

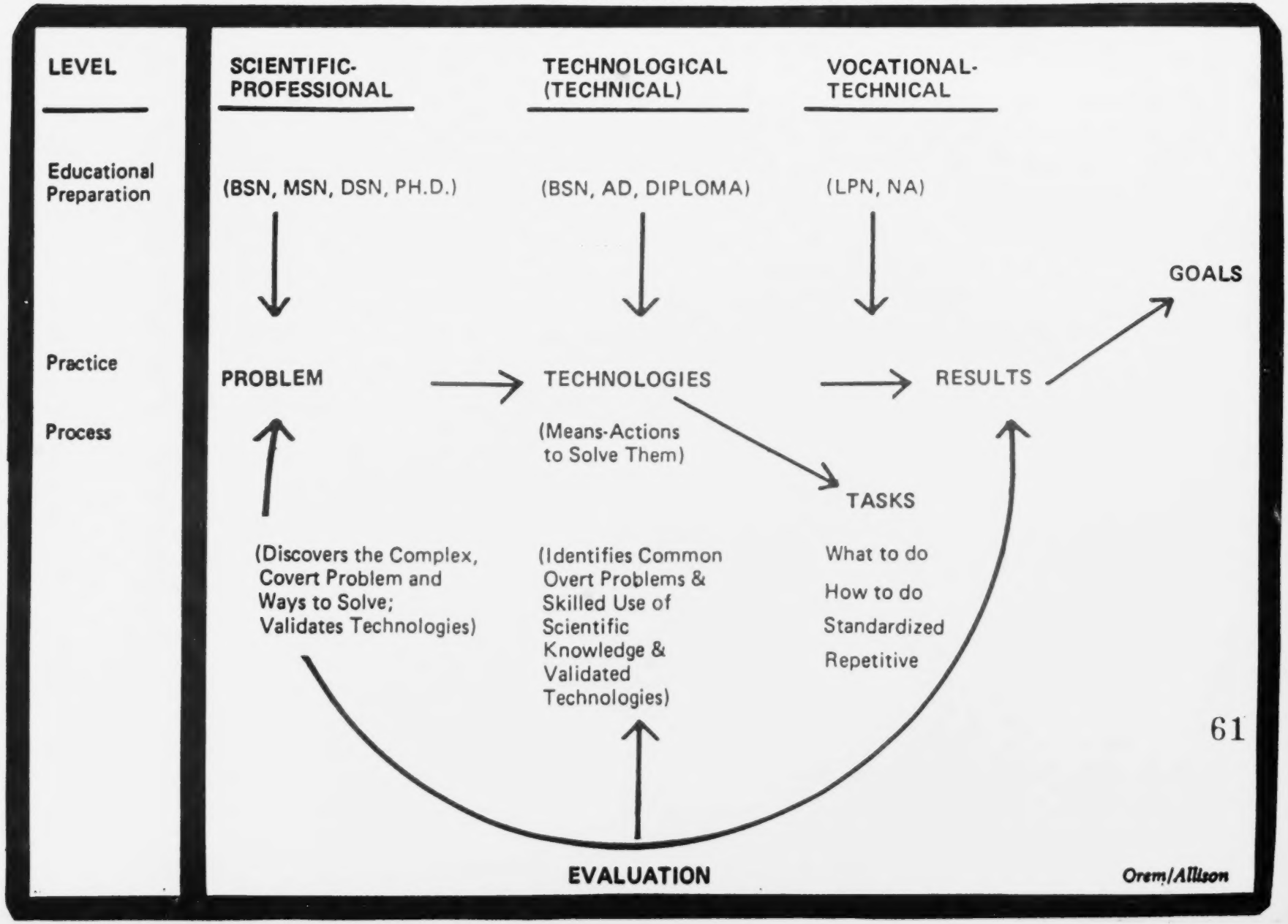
5. Many new graduates will need to adjust to the discipline of the nursing work world and the demands of a 24-hour service operation.

6. New graduates of all programs need assistance in planning and organizing their work assignments in caring for groups of patients.

7. New graduates (and some experienced ones too) need assistance in planning and supervising the work of others. Associate degree graduates particularly

FIGURE 1

ROLES AND FUNCTIONS OF DIFFERENT LEVELS OF NURSING PERSONNEL



need help in this area since leadership is not generally part of their educational program but is frequently required in the work place.

8. Baccalaureate graduates will have a concept of self as a beginning practitioner responsible and accountable for the nursing care--for complete management throughout the interval of care, assisted in this by other nursing workers. The associate degree nurse, on the other hand, perceives self as assisting in the care of patients, managing common overt nursing problems through use of known validated nursing technologies.

9. Baccalaureate graduates have a beginning knowledge of nursing research and statistics, know how to use the nursing literature, and are able to carry out small study projects as needed. BSN graduates are self-directed, able to function independently with minimal guidance, and are professionally committed to a career in nursing, which they evidence by seeking job promotions and advanced education.

10. Finally, all nurses will have some idea about the nature of nursing, that is, what they are trying to accomplish for and with patients. Usually, however, it is just loosely described as "better patient care."

3. Findings.

Most of the identified expectations are borne out in practice. Obviously, there are exceptions by reason of individual differences in nurses, cultural values held by young women (for example, Southern women as compared to those from other areas of the country), and differences in the various educational programs.

1. With reference to the expectation that most nurses will accept the need to work flexible hours, in reality, most want day work and weekends off. Baccalaureate graduates are more likely to seek jobs that provide the preferred hours. Associate degree nurses are more likely to work the less desirable evening and night shifts (perhaps because some are older and willing to fit these more lucrative hours into their personal life schedules).

2. In general, the greatest weaknesses in all of our registered nurses, baccalaureate and master's included, are the lack of understanding of the concept of complete case management and their inability to competently and completely document the nursing process. By case management, I mean the general staff nurse assumes full responsibility and accountability for managing the nursing care from hospital admission through discharge. For the nurse clinicians, this means continuing to follow their own patients on an outpatient basis as well as to oversee all patients on their service for as long as rehabilitation nursing is needed. For hospital patients, "primary" nursing is one approach taken by nurse managers to address this problem. However, internalization of it and commitment to case management as values and requirements of the professional have not yet occurred in many instances. Unfortunately, in too many of our service agencies, complete case management is neither recognized as necessary in practice nor is it made possible.

The nursing process is, at best, extremely fragmented. Isolated steps are performed, such as initial assessments and care plans, but there is little or no follow-up to determine reasons for changes in patient status and whether care plans are revised and updated accordingly. Few nurses know how to summarize the nursing case upon discharge. This too requires review of the progress made by their patients and should include projection of future goals to be achieved and actions to be taken.

Documentation is viewed as a burden which must be done because it is required and not because it helps the nurse think through what he/she is planning and doing for patients. Most nurses would rather be "doing" nursing than analyzing the process on paper. They are comfortable recording observations of the "here and now" about their patients, but have great difficulty critically analyzing their work for and with the patient. The work load is heavy and anything beyond minimal documentation takes time. Their defense is to say, "Patient needs come first." Perhaps, in our agencies not enough value and emphasis have been placed on providing time and reward for carrying out and documenting the nursing process completely and successfully.

Most nurses have difficulty making a nursing diagnosis, although they have a general idea about the types of nursing problems to be dealt with. Most need structured nursing assessment tools to guide their thinking diagnostically. Most recently, some are trying to use the National Nursing Diagnoses list. However, most need an organizing framework which establishes the focus of nursing and serves to delineate its scope and boundaries. An adequate theory of nursing serves that purpose of identifying the particular phenomena of concern to nurses and thereby guides nursing's mode of inquiry. An adequate theory of nursing should provide structure, a framework, for systematic thinking about nursing. In our view, the phenomena of legitimate concern to the nurse are the self-care deficits of patients and the reasons for them. Our documentation tools and, indeed, our whole nursing program are based upon Dorothea Orem's Self-Care Deficit Theory of Nursing. Our tools are designed so that even nurses unfamiliar with the theory can use them. As the nurses become more knowledgeable about the theory and their patients, integration into clinical practice occurs, and there is less need to depend upon the structured tools.

Nursing care plans also tend to be general and vague. Nursing actions prescribed are not specific, especially those of the associate degree graduate. In comparison, care plans of baccalaureate graduates usually are more comprehensive and individualized to their patients. Again, few nurses of either group perceive the need to review previous plans to revise and update them according to the changes in the status of the patient or to indicate the effectiveness or the ineffectiveness of the nursing actions previously prescribed.

In essence, we find that, at best, performance of the nursing process is at the technical or technological level of practice--nurses document what happens and what is done at specific points in time but do not evaluate what has occurred over a longer period and why.

Even master's degree graduates who have had no previous experience with case management or personally have not carried out the full nursing process have difficulty understanding the full meaning of case management. Some clinicians tend to focus on consultation and perform selected aspects of care--such as establishing patient education classes and carrying out discharge planning. They do not assume full clinical responsibility for any one complex case that requires the expert knowledge and skills of the advanced professional. To overcome this limitation in all of our nurses, case management through the complete nursing process is required. Each patient is assigned his or her own nurse throughout his or her hospital stay, regardless of the mode of delivery--primary, team or modular nursing--that may be used on the service.

3. With respect to the functioning of associate degree graduates, we are fortunate to have a strong program in our area. The nursing directors are pleased with the graduates, who are rapidly assimilated into their organizations and function well under supervision at the technical level of practice. They provide a reliable, stable work force. Their skills in the nursing process, as indicated earlier, are limited. This limitation is particularly noted in our home care program where complete precise documentation is essential for reimbursement. Previously, we had only employed baccalaureate nurses in home health because of their stronger and broader educational base and ability to work independently. Recently, we have accepted two mature AD nurses who were eager to work with patients at home and who agreed to go back to school for their degree. No matter what the level of education, a minimum of one year of general nursing experience is required to be accepted for employment in home health.

   Although some associate degree graduates have assumed management positions beyond their capabilities and preparation in other agencies, we may promote those who exhibit natural leadership abilities to a first line supervisory position. On-the-job training and continuing education are provided to assist them to assume these responsibilities. Most AD nurses, however, prefer to give direct care to patients and do not desire management responsibilities.

4. Baccalaureate graduates tend to go in one of two directions. Some tend to blend into the work force, functioning primarily at a technical level, carrying out the routines, doing the daily work as assigned, and becoming no more involved than this--it's a job. Others are more involved doing excellent work, demonstrating leadership and initiative. They make a definitive contribution to our patients and to the welfare of the organization. These nurses move ahead, seek promotions, and continue with their education. Our environment encourages this, and at present we have a number of nurses enrolled in graduate programs.

5. There is another category of nurse that cannot be labeled by degree. These nurses tend to look down upon the "tasks" of providing personal daily care to patients, such as bathing, toileting, and feeding. They view it as "aides" work which does not require their time or effort.

6. Master's degree graduates are the most professionally qualified to provide the clinical leadership needed for our disability category services and to oversee

all patients on the service. These clinicians are expected to manage a limited case load of patients and serve as nurse consultant for others. They are the experts able to develop the systems of care needed for the particular patient population and are the ones to teach and guide other nurses in providing the specialty care required.

Few clinical graduate programs in our area meet our specific needs in rehabilitation. Consequently, we employ master's degree graduates from a variety of programs, such as community and mental health nursing, and help them develop their specialty practice on-the-job through self-study and continuing education programs. Certification in rehabilitation nursing is a job expectation for them as well.

4. Hire a Full Spectrum of Nurses.

It is apparent that we hire a full spectrum of nurses. In doing so, we have tried to sort out and utilize each type or level of nurse in accord with the model presented earlier. Development of different cost-effective models for delivery of nursing is needed. "Primary nursing" may not be the best method of delivery as some believe. Unfortunately, in too many nursing service agencies all nurses are employed to function at the technical or technological level of practice with little or no differentiation for professional roles and functions. Even master's degree graduates, with the exception perhaps of mental health nurses, are often placed in positions primarily concerned with nursing management or staff development. Some may serve as nursing consultants but not enough are engaged as practicing nurse clinicians because it is expensive. We deal with this cost by charging for their services because it is over and above routine care. It is my belief, moreover, that we cannot raise the level of nursing practice unless we employ the highest level of professionally-prepared nurse to be directly involved in practice. The master's degree nurse is educated to function at the scientific level of practice and is the one needed for this purpose at this time.

Studies are needed to develop economically feasible organizational models for delivery of nursing which utilize both master's and baccalaureate graduates as the professional practitioners of nursing. These practitioners would be responsible for managing nursing cases, assisted by associate degree nurses. The associates would perform routine nursing actions as prescribed by the professionals. In our area the Veterans Hospital is experimenting with a model in which licensed practical nurses work under the direction of the baccalaureate prepared nurse. Nevertheless, before

we implement any model for delivery of nursing, I am concerned that we clearly identify the nature of the product (service) we are trying to produce and the nursing outcomes to be achieved for patients through that service.

I have worked in a number of situations to help nurses improve their practice, not only in my present position but previously at a large teaching medical center. In each project, it was necessary to establish the focus of nursing. The nurses needed to know what they were working toward. This was done through development of the tools and system for delivery of nursing which enabled nurses to more clearly know what they were trying to achieve and how to do it. Dorothea Orem's Self-Care Deficit Theory of Nursing served effectively as the foundation for this in every situation. When practicing nurses at any level have been helped to clearly understand their domain of practice and nursing systems which enable them to practice at a very high level are developed by a professional, we not only develop capable, satisfied, and dedicated nurses, we maximize the whole of nursing effort as well.

When I undertook my present position at the rehabilitation center, I had a professional model for practice in mind. There would be a separate professional staff of clinical nurse specialist (master's graduates) and rehab nurse clinicians (baccalaureate graduates). These nurses would be responsible for overseeing all patients on the services to which they were assigned, managing selected cases, prescribing nursing as needed on consultation in other situations, and performing special functions as required. The technologically-prepared nurses would be organized in the traditional fashion, assigned by place and shift, to an inpatient unit under the direction of a master's prepared nurse manager. The model did not work well at that time; the chief reason was that not enough general staff nurses were employed to carry out many of the nursing actions prescribed by the clinicians. This created conflicts for both the staff nurses and the nurse managers.

As a consequence, after a survey of the nurses, we reorganized. Master's prepared nurses were made chief nurses or clinical directors for each major disability category service; they are held responsible for both clinical and management functions. To assist them in each area, a nurse clinician and head nurse are assigned to the service. The chief nurse and nurse clinician are responsible for designing the nursing systems to meet patient requirements for nursing. They

determine the common types of self-care deficits manifested and identify, in general, the capabilities and limitations in their patient population, including dependent caregivers, to meet them. From this, they establish standards of care to be met, determine the types of nursing actions needed, and the types and numbers of nurses required to perform them. They also develop the tools and determine the technologies needed to help patients and their families overcome their self-care limitations and deficits.

The head nurse, a baccalaureate graduate, in collaboration with the clinical director is responsible for the 24-hour daily operation of an inpatient unit. The head nurse guides and directs the work of the staff nurses in the implementation of the designed systems of care and works closely with the nurse clinician as well. While the inpatient staff are bound by time and place, the nurse clinicians work flexible hours to meet patient/family needs. They serve patients in a variety of settings--on the inpatient unit, in clinic, or occasional home visits, through telephone follow-up, and may visit other hospitals to evaluate patients for admission for rehabilitation. In addition, they are the nursing liaison for patients served by our outpatient facilities.

Initially, we experimented with promoting experienced baccalaureate graduates, as the beginning professionals, to our clinician positions. This was not successful from the larger patient population perspective. The BS clinician tended to limit her services to selected individual patients and did not see the needs of the population as a whole; nor were they able to develop and test approaches or methods to improve care for all patients on the service. They tended to focus more on performing functions, such as developing a few patient education materials or classes, attending rounds and staffings, and performing discharge planning for some more complicated patients.

Our conceptualization was to give the baccalaureate nurse in this position opportunities to function in a variety of roles--as practitioner, scholar, teacher, consultant--and also to perform selected aspects of management, all under the preceptorship of a master's prepared nurse.[2] Ideally, this career ladder position should have been articulated with a master's degree program, an option not available to us since we are not connected with a university. To obtain greater productivity from this position for the benefit of our patients and our organization, as of this

year, we have decided to employ only graduates of master's degree programs for these positions in the future.

Upon employment, RNs from the different undergraduate programs are expected to meet the same requirements for our general staff nurse positions, even though we pay a $50 per month differential for the baccalaureate graduate. Our reasons for paying this amount are that the baccalaureate graduate has additional experience (in school) and this sum is used as a recruitment incentive. Job differentiation occurs thereafter through our promotional line. Both associate degree and baccalaureate nurses may qualify for our first level of promotion as rehabilitation nurse if they meet the qualifications. This position involves additional clinical and management responsibilities. The AD and BS graduate may qualify for a shift charge nurse position at this level. Higher management level or specialty positions, such as head nurse, infection control nurse, urology, or employee health nurse, are reserved for baccalaureate degree nurses. These positions require scholarship and beginning research skills for independent work in collecting and organizing data, reviewing the literature, and writing reports.

Baccalaureate nurses are preferred in home health also for many of the reasons previously cited. They are familiar with community resources, are able to deal with the unexpected in an unstructured environment, have physical assessment skills, and also have a strong science base which especially helps when implementing high technology in the home. Even our mental health clinical nurse specialist must be able to assess her patients physically as well as psychologically in order to safely and comprehensively meet the needs of her homebound patients. In home health, furthermore, case management has a broader meaning because it involves coordination of all health services required by the patients assigned, not just nursing. This reponsibility requires leadership and strong interpersonal skills, areas in which nurses with less education may have some difficulty.

In our rehabilitation setting as well as in home health, the nurses enjoy freedom to practice--freedom to make decisions and write nursing orders--and appreciate having a strong theoretical base upon which to develop their practice. As our nurses have become more knowledgeable and confident about their domain of practice, they have earned the respect of their multidisciplinary colleagues and recognition for the contribution nursing has to make to our patients and the rehabilitation team.

5. Choice of Nursing Model Used.

In the past, nursing directors have hired nurses primarily for their technical know-how and competence to work in structured service situations that tended to be organized along traditional authoritarian lines. While nurse managers have experimented with various models for delivery of nursing--team, primary, and so forth--attention has been placed more upon how the workers are organized and less upon the product to be produced. Only recently has the literature addressed the notion of utilizing a theory of nursing in a nursing service organization. (Usually it is ignored or not even conceived of as useful.) Should nurse managers simply put a number of skilled workers on the production line, with each of them assigned a specific function without identifying the end product to be achieved through their efforts? Wouldn't this be like trying to build a house without a blueprint and construction plan? Interestingly enough, through our art of nursing (intuitively, and with common sense) we get results, although we may not specifically be able to say what they are. But, in this age of science, we must go further than this if we are to systematically develop nursing and nursing knowledge. We need an explicit cognitive structure that identifies the focus and lays out the domain of nursing in ways that have utility in practice.

Having worked with Dorothea Orem's Self-Care Deficit Theory of Nursing since the 1960s, I have found that many nurses in a variety of situations are operating upon the premises of Orem's theory without even knowing it. Examples can be found in the Joint Commission on Accreditation of Hospitals (JCAH) criteria for the nursing process and in teaching protocols used for accepting patients on high technology programs in home health. The reason for this is that the theory addresses the real world of the patients--what they are doing to manage their own health care, what they can, will, and should do, and the reasons why they or their caregivers are unable to do so. Very simply, the theory says that nursing is the means or medium through which individuals are helped to overcome self-care deficits and to increase their capabilities for self (or dependent) care. Nursing substitutes or compensates for that health or health-related continuing care which individuals cannot manage now or potentially in the future, and helps increase their abilities to do so.[1] From a nurse administrator's point of view, the theory has tremendous utility for developing and organizing nursing practice to serve patient populations. Research to demonstrate this utility is needed.

Nurses come to us filled with information, eager to use their knowledge and employ their skills on behalf of patients. They have knowledge from the humanities and from the biological, behavioral, and medical sciences, but need help to put this information together from a nursing frame of reference. Orem's theory establishes the nursing focus and provides a conceptual framework through and upon which to articulate and relate these bodies of knowledge to nursing. Orem's theory, therefore, provides the structure upon which we can "hang our hats" and does so, in my view, better than any other current theory. Articulation of Orem's theory of nursing with other bodies of knowledge certainly is another area for nursing research.

Summary and Conclusions

In summary, with the vast changes in health care services today and the increasing emphasis on the consumer as participant in his own health care, there is one health care discipline specifically educated and prepared to help persons in society learn to manage their own health care more effectively and assist them to utilize well the various health care services available to them. When a person in society is unable to manage his/her self or dependent care, it is nursing that makes the difference and substitutes or compensates for the lack. For these reasons, Orem's Self-Care Deficit Theory of Nursing is particularly relevant and can provide the substantive structure for developing nursing practice and nurses. It is a model deserving to be tested in practice and through nursing research.

With respect to our practitioners of nursing, I am concerned about the lack of depth in knowledge in too many of them and their lack of a clear nursing focus. They tend to perform the technologies of nursing competently, based on experience and the creative art of the nurse, but not from a nursing science base. Moreover, I think we are in error to try to produce a professional nurse through a two-year, upper-division baccalaureate program. It is not enough. There simply is not enough time to learn all that needs to be learned for professional practice. I, personally, have not seen full professional functioning begin until a nurse has completed a master's degree program. Upon completion of these programs, the nurses have a broader and deeper understanding about the profession and have, at least, an acquaintance with current theories of nursing--fortunately, others have a more indepth exposure to one or more theories of nursing.

I would propose a closer tie between nursing education and nursing service agencies through development of certified residency programs for nurses in which in-depth experience and training under the guidance of master's-prepared clinicians in the service agency are provided. A well-developed practicum articulated with graduate coursework in a university might be developed not unlike the practitioner-scholar program I mentioned earlier. Upon completion of the training program and coursework, we would have knowledgeable and competent professional practitioners.

Nursing has unlimited opportunities to expand and grow with our health care industry--for that is what it has become. To do so, nursing must be clear about the contribution our profession has to make to the health care system, plan carefully how to create our product, and demonstrate our results in cost-effective ways. Education and nursing service must be creative and work together to meet these challenges by developing better qualified nurses, productive systems of nursing, and better systems for delivery of nursing.

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ALTERNATIVE APPROACHES TO CARE FOR THE ELDERLY: WHAT NURSES NEED TO KNOW

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Originally I intended to title this talk "New Approaches to Caring for the Elderly," but when I considered that the approaches I was going to focus on are not really new, I had to call them alternative approaches--at least alternatives to the traditional way of caring for the elderly sick, such as hospital or nursing home care. As the Bible says, "There is nothing new under the sun." These approaches are as old as the institution of the home and family. As we in the health care profession come face to face with the phenomenon of the growing number of aged individuals in our society, we are forced to take a deep breath. The figures loom before us, and they are indeed mind-boggling: In 1980 there were 376 million people age 60 and over, and in 2020 this figure will be over 1 billion. As we have learned better to stave off heart disease, strokes, cancer and other killers, an increasing percentage of the total population are living not just past 65 but on into their 80s, 90s, and beyond. It is these "oldest-old" folks--often mentally or physically impaired, alone, depressed--who pose the major problems for the coming years. It is they who will strain their families with demands for personal care and financial support. It is they who will need more of such community help as meals on wheels, homemaker services, and special housing. It is they who require the hospital and nursing home beds that further burden federal and state budgets. There is already talk of some sort of rationing of health care.

Fortunately, most of today's younger-old are healthy, active, and relatively well off; they think of themselves as middle-aged rather than old. Although many health problems come to the surface after retirement, no hard research has been done to ascertain the degree of correlation between illness and loss of the daily routine of going to work. At the turn of the century, the average male spent 3 percent of his lifetime in retirement; in this decade he spends 20 percent. Almost two-thirds of all workers retire before age 65. How many of them take the time and trouble to prepare for their retirement years, beyond dreaming of travel and brief

visits to children and grandchildren? With much time on their hands and without the health insurance provided by their full-time jobs, many people are seeking ways to cover the rising costs of health care, especially if they did not practice good health habits throughout their lives. Nurses should be acting to instill habits for a long healthy life in young people. This is a major area that cries out for positive action. The man or woman who retires at 65 still has 25-30 years of life to look forward to.

The other side of the coin is that one of six elders has children 65 and over. Many people who are close to retirement are also acting as caregivers for the old. The cold, hard facts are that one may prepare for a productive and financially comfortable retirement and then find oneself a caregiver for a 90-year-old parent or parents for the next 10 years. It is also a fact that 210 Americans reach age 100 every week, so we must prepare for long, healthy lives, and also prepare to become caregivers, especially if we are women. Women are 10 times more likely than men to serve as caregivers.

What does all this mean to the health professions? What are the implications for nursing education? We can no longer go on ignoring the aged, and must address their problems with an informed knowledge base. We do not assign students without a good basis in pediatrics to an 8-year-old surgical patient. Why do we allow students to take the responsibility for an 80-year-old surgical patient without such a knowledge base in geriatrics? Aging is a lifelong process, beginning at birth. For our purposes, we can consider it as beginning with mature adulthood. Health providers need to be taught that the elderly constitute a special group, with distinct individual needs arising from progressive physiological and biochemical changes of aging and socioeconomic conditions. In contrast to the myth that all old people are alike, they actually tend to differ more and more from each other as they get older. Superimposed on the genetic differences they were born with are the effects of everything else that has happened to them in life. Our students need to know all about physiological aging. They need to be able to differentiate normal from abnormal aging changes. They should incorporate prevention into their thinking at all stages of their education and practice. We can make a distinction between chronic diseases, such as arthritis and multiple sclerosis, over which the individual has little, if any control and the much larger group of diseases, including coronary heart disease and many types of cancer, that are known to be responsive to

behavioral risk-factors, such as smoking, nutrition, and exercise. Preventive gerontology, the effort to prevent or postpone the onset of this latter category of diseases, should be one of the major thrusts in basic nursing education.

Nurses must be aware of the elderly's increased vulnerability to stress, to injury, and to infection. The 85-year-old man in the hospital bed or nursing home may never recover from the compression fracture of the vertebra that results when an impatient aide pulls him to his feet to be taken to the bathroom. The 76-year-old woman lying in bed who needs to urinate and cannot call for help because her call-bell is out of reach and who may try to crawl over the siderails or off the foot of the bed will almost certainly fall on the floor. If she sustains a fracture of the hip or a subdural hematoma, she may not recover due to prolonged bed rest and the complications thereof. At the very least her hospitalization will be prolonged and costly--not to mention the litigation that will ensue as soon as her family finds a lawyer.

A major focus should be the nutrition of elderly people in our population. Hospitalized elderly patients are frequently undernourished.[1] In a Swedish study, up to one-third of the geriatric patients had signs of malnutrition when they were first admitted to the hospital. These were psychogeriatric, medical emergency, and acute stroke patients. During a hospital stay elderly patients are at risk of becoming malnourished. This is especially true for those who have infections, malignancy, severe cardiovascular diseases, strokes associated with eating problems and for those with poor dental status. What of the patient who is kept NPO for testing day after day? In one study hospitalized patients recovering from femoral neck fractures were found to be eating less that 50 percent of nutrient requirements of protein, calcium, and vitamins; and this in spite of adequate food being offered. Although health professionals are aware of all the dangers of iatrogenic complications and nosocomial infections, the use of acute-care hospitals by the elderly has been steadily increasing. The average length of stay and the total hospital days per year escalate with advancing age, with a steep rise in the 75 and older group. Descriptive studies of the outcome of hospital admission of the elderly are rare. A few investigators have developed indices for predicting elderly patients' length of stay, targeting those patients who would benefit most from early discharge planning. A recent study done in California showed that no patient had an improvement in

level of care as a result of acute hospitalization. Even those with normal mental status or strong social supports deteriorated.[2] Obviously hospitals are fraught with danger for the elderly.

In 1974 an English study that generated some interest in the United States found that the addition of a geriatric consultant to the team on an acute medical ward helped to shorten the average length of stay of geriatric patients and a larger number were discharged to their homes rather than to institutions. Thus a movement to open geriatric assessment and evaluation units was underway. The findings have been replicated in more recent studies, especially the 1981 research of Rubinstein, et al, which described the patient outcomes of those treated in the geriatric evaluation unit at the Sepulveda Veterans Administration Medical Center. At present there are 12 evaluation units operating in the V.A. hospital system. Many community hospitals are opening such units as they begin to realize that the hospitalization, not the illness, may be the deciding factor in the functional ability of the frail elderly at discharge. A recently published description[3] of such a unit at a Rochester, New York, hospital is an example of how nursing makes the difference in these units. A special feature of this 12-bed unit is that nurses are allowed to function to the full level of the New York State Nurse Practice Act, which means they can "diagnose and treat human response to illness." This allows for prompt nursing assessment and intervention in acute medical conditions. The nursing staff writes orders for activity, diet, referrals to O.T. and P.T. Rehabilitation techniques are a major focus, and the results showed a drastic improvement in functional status. There was a lower readmission rate, which saves money for the hospital under DRGs. The article did not mention what, if any, special training the staff received. It is interesting to note that the authors feel that the multidisciplinary approach in this unit has a great effect on the morale and self-motivation of the staff. It also would be interesting to see if this could be quantified and compared with another more traditional unit.

Is there a way to keep elderly people out of hospital? Can they be treated safely and effectively at home? This question has been partially answered by the burgeoning home health care businesses. They have been successful, as one can see from the large number of agencies established across the country, beginning in the 70s. A recent editorial in The American Nurse describes a collaborative family medical and nursing practice which provides health care to homebound patients.

Most of the patients are elderly and do not have the support of family or friends. They have multiple, chronic health problems but would rather risk dying than go to a hospital when a crisis occurs. They can't get to a doctor, nor can they get a doctor to come to their home. These are patients who fall through the cracks in Medicare and home health agencies. To quote the author, Veneta Masson, "one of the charges leveled at nurses who advocate expanded third-party reimbursement for home health services is that home care is an add-on expense, that it fails to reduce the total cost of health care. Not so if the nurse is actively managing the patient's treatment at home, eliminating the need for expensive trips to the physician or emergency room to verify findings the nurse has already made or to carry out procedures that could, with a little ingenuity, be done at home."[4]

Nursing is the perfect solution to the long-term care of the homebound and is an antidote to escalating health care costs. A bill currently before Congress, the Medicare Community Nursing and Ambulatory Care Act of 1986, would provide direct payment for nursing services. Patients could receive care in community-based centers or in their homes. You as educators will be called upon to provide the knowledge and skills nurses need to perform in this setting.

St. Paul, Minnesota, has developed a "block nurse" program that provides neighborhood care for the elderly in their homes. Using local professional and volunteer help, the program has reduced loneliness among the elderly while avoiding premature and costly nursing home placement. The Ford Foundation honored the city for its "innovative" solution to a local problem. An award of $100,000 was given to further its work. What is being called innovative here is really an old concept, borrowed from the block nurses in China and the feldshers in Russia. In the early 20th century the Kentucky-based frontier nurses did the same thing in a rural setting, traveling by horseback to visit the sick and the disabled.

The number of elderly Americans needing nursing care in their homes is increasing steadily while demographic and sociological changes threaten the family structure that has traditionally provided that care. More than six-and-a-half million Americans 65 and older need long-term care; of these, 1.4 million are in nursing homes. In most cases families assist them. However, there are fewer family members available for this care than in previous generations. More female members of the family are likely to be in the work force today. There is a trend toward

state-sponsored programs to provide support for caregivers who are willing to keep their aged in the home. Florida now has such a program, still in its infancy, however. Pilot studies have shown that providing these services does not inhibit caregiving but encourages providers to continue their efforts. Other examples of the caregiver support are respite care, day care for the elderly, and home help, such as chore services, overnight and temporary care.

What is respite care? It is a temporary relief from a burden. Recently two hospitals in South Florida began offering weekend respite care for elderly persons. They charge from $75 for a semi-private room to $100 for a private room per night, with nursing care and meals, of course. Although it would be rather expensive if needed on a regular basis, it can be of great help if a caregiver needs a short vacation once in a while--and who does not?

Another type of respite is short-term respite in nursing homes. One of the first things I did at the Veterans Administration Medical Center was to set up a geriatric clinic to follow patients after discharge from the V.A. nursing home and extended care unit. Many of these patients had a spouse, daughter, or sister-in-law acting as their caregiver. There was always that question in their mind, "What will happen if I get sick and can no longer care for him?" They were told that, if needed, they could fall back upon the nursing home. This often gave them the needed security to allow them to take their relatives home and to go on caring for them. We initiated an unwritten policy that beds, if available, would be used by our clinic patients for respite care, when appropriate. Because the geriatric clinic was located in the nursing home, there was free flow of communication concerning the patient's condition and the reason for the readmission. In Florida there has been tremendous population growth over the last decade. It is now the most populous state in the Southeast, ranking seventh in the nation. Even more dramatic, as you are well aware, is the growth of our elderly population.

We are experiencing an epidemic of Senile Dementia of the Alzheimer Type (SDAT). Government agencies are usually slow to follow the will and needs of the people. The 1985 Florida legislature, however, passed an act relating to Alzheimer's Disease (HB 77) creating a network of programs designed to address the needs of Alzheimer patients and their caregivers. It provides only a drop in the proverbial bucket as far as the vast needs of our aging population are concerned. We are 50th

in rank order of states in the amount we spend on health and human services. This in view of the fact that we will have over one-third million people over 85 by the year 2000, which is only 14 years away. It is estimated that over 20 percent of those who reach 80 will suffer a moderate to severe form of dementia. That means that in Florida alone, there will be between 60,000 to 75,000 people suffering from a dementing illness by the year 2000. Twelve states now have provided some type of program to deal with this new epidemic.

The Florida bill created four memory disorder clinics, which will provide diagnostic services, training materials, conferences and research, four model adult day care programs were established, and four respite centers were developed. These will provide funds to help caregivers get some relief, either by paying for day care or a companion to stay with the patient for a few hours a day. The funds are quite limited. One center, in Pensacola, was allotted only $8,000 for the first year. Training is a component of all elements in the network. Nurses should be involved with all of these programs, providing the knowledge and acting as consultants for the caregivers, individually and in support groups. For example, nurses can make referrals, assess equipment needs, assess safety needs to prevent falls, etc., assess need for other professional and/or non-professional help, institute bowel and bladder programs, and teach proper body mechanics to caregivers.

The professional nurse involved must have skills to provide counseling. The anger and guilt that the caregiver experiences, the role-reversal that takes place when the child becomes the parent and the parent the child, lead to depression in more than half the caregivers themselves. The nurse can provide emotional support, assist caregivers in legal and bureaucratic hassles, determine caregivers' medical sophistication and provide interpretation, determine comfort in expressing concerns, assess caregivers' knowledge of aging, teach stress management, help formulate a home emergency plan, and lead the way in forming community support groups.

Adult day care provides needed services for frail elderly while allowing them to live in their own homes. It provides respite care for caregivers during daytime hours and for shorter periods, rather than long continuous institutionalization. It facilitates a more normal life for both patient and caregiver. In terms of the health care industry, adult day care has emerged as one of its new outlets. In 1974 there

were approximately 15 adult day care programs in the United States. A bias toward institutional care rather than services in the home and promotion of self-care was evident. Reimbursement was and continues to be a problem. Most of the 800 active programs in the U.S. today have some state and federal funding and often charge a fee on a sliding scale. Adult day care has grown because it has combined a societal need with participant satisfaction in a financially feasible way. Family stress and tension brought on by caring for an impaired relative are reduced. An overburdened caregiver may think first of hospitalizing or finding a nursing home for the family member. They may not be aware of the alternatives. Do nurses make referrals to adult day care programs? Do they understand the purpose and advantages of day care? Do they recognize that the health of elderly caregivers is at risk? They need to be equipped with the skills to provide problem-solving assistance.

Most community-based adult day care centers are considered a social model, with staff composed of aides and an activity director under the direction of an R.N. or M.S.W. The health care model of day care is based on the concept of the day hospital, which is borrowed from the United Kingdom. These programs are usually staffed with nurses and therapists of all varieties: physical, corrective, occupational, recreational, speech, etc. There may be a medical director who has an interest in geriatrics, usually with an R.N. with special training in geriatrics and gerontology as the director. Our program has a part-time dietitian and physician. The staff become the surrogate family of the participant, especially for those participants who live alone, as about half of ours do.

The V.A. became interested in adult day care when the statistics on the number of veterans over 65 became apparent. In September 1985, the veteran population over 65 was 18.9 percent of all males of that age; according to projections that proportion will reach more than 60 percent by 2000--two of three men over 65 in the United States will be veterans. These men will be vulnerable to all the problems of aging.

A few V.A.-sponsored day care programs, notably in North Chicago and Palo Alto, have been in existence for some years. In Loma Linda, California, an experimental program was started in 1981 with a $50,000 grant from the state of California. V.A. staff were employed to develop the program, and an American Legion Post was made available for use as a center. The participants were veterans

and non-veterans. The program still functions, without V.A. staffing. A few bootleg operations were started at other centers. In Butler, Pennsylvania, a geriatric nurse practitioner started a small 3-days-a-week operation in an unused section of the V.A. nursing home. It is now fully staffed and open 5 days.

With the increase in cost of health care, more of the elderly veterans in the community will turn toward the V.A. health care system. More and more, health professionals are looking at the home and family as a source of health care. The family is one of our most rapidly dwindling resources.

Through the V.A. programs, family members get a needed respite and feel they can better cope with the problems they have. Opportunity is provided for them to share their concerns with the social worker.

The V.A. adult day health care programs were set up with major focus on rehabilitation. Four centers across the country were set up as mandated by Congress. Our program is located at South Shore Hospital on Miami Beach.

The nurse practitioner makes her health assessment on each participant and monitors the chronic health problems of the participants. Weekly health promotion classes are held.

A physician assigned to our program spends about six hours a week at our center. She was a geriatric fellow last year and so is well attuned to our patients' needs.

There is a morning exercise group for a full 30 minutes, followed by a walk outdoors, weather permitting. Keeping the body functioning at its optimal level is a priority. Certain veterans need individual attention from the corrective and/or occupational therapist. Our center has a variety of therapy equipment and a large whirlpool tub.

We feel that this program provides many benefits. These include less dependence on family members, less utilization of traditional acute care facilities, and decreased exacerbation of chronic health problems. In addition, one notes changes in behavior after a time. The isolated person reaches out, the depressed begin to take an interest in life. Participants state they feel an increased sense of well-being. We are hoping to demonstrate a decrease in repeat visits to the drop-in clinics, and less hospitalization.

It is easy to say that whenever and wherever possible, the elderly should be able to stay in their own home, or outside of institutions. Nevertheless, advanced age will necessitate a spectrum of services and programs to help them.

Let us talk about nursing homes for a few minutes. You may be familiar with the now rather passe but formerly well established practice of taking first-semester nursing students into nursing homes for their first bedside clinical experience. This practice served to alienate a whole generation of nurses from geriatric patients. . . . I hope that some day nursing homes will exist that are truly worthy of the title "home," and where we will find quality nursing practiced. Perhaps some of the "teaching nursing homes" that are being developed may serve as wonderful clinical experiences for nursing students and graduates. Why should an elderly person dread the thought of having to go to a nursing home? Do they have to be so dreadful? This is truly a challenge for our profession. . . .

The increase in number of people reaching old age is a tremendous success story. It is due to improvements in public health, reductions in childhood mortality and infectious diseases, new discoveries about disease and their treatment, and changes in living habits. These have led us to a new problem--how to meet the needs of this changing population.

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UNITY IN NURSING—A PUBLIC IMPERATIVE

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If one scanned the articles and "Letters to the Editor" in various periodicals or journals from the 1900s on, and if one collected all of those paradoxical stances and "outpourings," it would provide an unbelievable quantity of grist for the sociological analysts' mill. It could produce an overwhelming sense of awe that the collective entity called nurses, or the collective noun called nursing, has even survived, much less thrived through deliberately or accidentally coming together for a thrust forward at significant points of advance. Our consistencies and inconsistencies are legion. So is our sibling rivalry. I might add that sibling rivalry is most apt to occur when parents have not prepared the other child for the new arrival--when these parents have not recognized that fighting and scrapping occurs because of the child's fear that the new arrival will take all of the attention, will be loved more, that he or she will be cast aside. If Johnny does one thing well, Tommy will try to outdo him rather than developing his own forte.

A far-flung analogy? Perhaps, but look at our history--sibling rivalry of organizations, of nursing service vs nursing education, of hospital nursing vs public health nursing, of baccalaureate education vs diploma, diploma vs associate degree, and on and on. I want to emphasize, however, that sibling rivalry handled well encourages growth and independent thought. Some of it is healthy. But who are the parents who can de-fuse the dispute? It is difficult to identify the real parents of nursing's many off-spring.

We have a deep need to belong, to be accepted, to relax, to be done with fighting. On the other hand, our learned patterns of response and behavior run deep. Sometimes we treat our organizations like mythical parents; we blindly do what "they say" or we threaten to run away from home if we disagree. We speak of "we" collectively when we like the course of events, we speak of "we and they" when we don't. Just as we near a quiet moment of reasoned thought and reciprocal dialogue, someone pushes the button, and off we go in frenzies of rhetoric and spurts of adrenalin that rev us past the moment of mutuality.

So many times in my years of nursing practice and education, I've gotten a lift in thinking, we're almost there, we can learn to live together. So many times I've seen us fail to make that uncomfortable step of commitment to change. As an optimist, I come to this meeting believing that we know we must get together. We know that we can make the last climb if we can just be sure who and where the snipers are, if there is space for all at the top of the hill.

As a realist, I know absolutely that we must get together. In our hearts, every one of us knows that "united we stand, divided we fall." While we have taken our family feuds to the streets, other occupational and professional families have established new settlements. They are engaging in health care, improving access, extending the neighborhood boundaries, and making less noise, while we remain trapped on our own terrains.

Nursing as a universal social need will survive. It is a priority for human survival. Nurses, as we now label ourselves, or as others label us, may not, certainly will not, exist in the same state of its current development. Unity in our purpose--our reason for being, our goals, direction for the good of others above the good of ourselves--is an urgent public imperative. The public ultimately decides who is and is not a profession by the prerogatives sanctioned. We earn the label if it is given; we don't just say it and make it so.

It seems particularly important to examine the obligation of unity within this group that makes up the Southern Council on Collegiate Education for Nursing--those in programs that lead to an associate degree and those in programs leading to baccalaureate and higher degrees. Unless we become hopelessly deadlocked and divisive, these two groups will sooner or later form the matrix for preparation for nursing practice--I use matrix in this case as the formative cell. Some of us in this region have been involved in the nationwide Kellogg projects, projects that gave considerable emphasis to building bridges between nursing education, particularly associate degree education, and nursing service. We all need shared partnership ventures with nursing service. As urgently, we need shared partnerships with each other. At one time we had a common bond in building those bridges. We still do I believe--and it can be the focus again. First, however, we must rebuild a common and stronger bond of relationship among ourselves--the two major divisions of nursing

education. Nursing services with a unified goal of patient care services cannot be forced into taking sides. They need all of our products. They do not need to have the problem of dealing with "spill-over discord" effects of our lack of unity and agreement in the educational setting. Neither should our graduates be hampered by such spilling over and burden. To free our new entrants from our history of discord borders on the nature of a morality issue.

Students are in desperate need of the positive aspects of our history, of a perspective on the steady, albeit erratic, progress of the tremendous impact that nursing has had and the vision that has been demonstrated by some very great early leaders--leaders who looked to methods of freeing nursing from apprenticeship; leaders who fostered a level of education and practice that would allow a profession to emerge, to flourish, to grow; a small core of leaders who could converse with other disciplines; leaders with statesmanship. We should all go back and read the papers of Isabel Stewart, the life of Lillian Wald, Isabel Hampton Robb, even the different levels of nursing that Florence Nightingale intended.

What is unity? It is not sameness. It is not dead-leveling. It is not coercive capitulation. It is not political expediency, although lack of it is politically explosive. In the context I view it here, I use the definition "oneness of a complex, organic whole, or of an interconnected series"--harmony or agreement. One cannot achieve harmony in music without at least two instruments or two voices. To go further in explicating words of this title, an imperative is defined as something "not to be avoided or evaded, urgent and necessary, obligatory." Public is, in this context, the general body of mankind. The heavy responsibility we bear then is the obligation to show our oneness as the complex whole of nursing, interconnected in purpose and responsive to this body we call clients, patients, or mankind. Other nurses with status needs aren't our mankind to serve; nor are legislators; nor are our organizations; nor are educational institutions that vie for student enrollment as the first issue; nor are hospital managers who would like to keep the lowest flat rate of pay for the most compliant interchangeable work force. Our mankind to serve is the persons who have health needs, who need to trust our working together to realize the greatest effectiveness of the knowledge and skills we each have to offer. When we get this ageement in perspective, all other parts of the structure of nursing and nursing education will fall into place.

Just a couple of years ago, everyone was very hep about a concerted drive to improve the image of nursing, to teach the public that we were the best bet for humanistic, cost-effective, continuous care--care that would help people achieve maximum access into the resources available and proper attention for chronic health problems. That drive for a new image, we postulated, would make the public see nursing as a full-fledged provider, as an essential part of any health care initiative--worthy of our hire, worthy of our recognition.

Something seems to have happened on the way to that forum. Suddenly we got into skirmishes about titling and licensure, the latter of which is a public prerogative. We made another mistake in placing solutions of difference and the definition of what we are licensed to do under the police power of state's rights, instead of placing the responsibility for the different extent of what we can do above the basic safety level squarely within the profession. The fray began again. This time educators--all of us--cannot blame nursing service, physicians, or any of our long familiar scapegoats. We may have our array of seconds in the background--but we are the duelists in search of a title.

Granted, some nursing service personnel still have a positive or negative set toward diploma, A.D., or baccalaureate graduates depending upon how which route or practice correlates with their own. More and more evident, however, is a unified effort in the nursing service setting to focus on the greater priority of seeking the right persons with the proper qualifications to meet the new pressing demands of nursing care--care that must be demonstrated to result in cost-efficient, effective care. There are some sharp, highly qualified persons in nursing service positions, and the old imbalance in qualifications between service and education is over. If we don't get our educational act together, and <u>soon</u>, it will be education lagging behind the new frontiers of knowledge in the practice arena. Should that happen we will have lost the core purpose of education--that of creating new frontiers of knowledge and preparing our graduates for the future. In our preoccupation to establish difference by listing non-tested practice competencies without attention to the cognitive competencies, development of critical thinking, the analystical skills necessary for reduction of bias, and fostering inculcation of the altruistic aims that we give lip service to, our voices become as tinkling brass to the public. Our

pronouncements that each is better than the other, or the same, then heralds a new wave of pharisees. Strange that we stop at the bacclaureate level and do not bother with nursing competencies for graduates with the master's degree.

On the premise that the future of nursing education can best be consolidated and strengthened by settling into two kinds of preparation for entry into the nursing care system (notice I did not use the word, levels) and that the public will be served best when we reach accord and clarity, I make a plea that we use our energies in the direction of current areas of consensus, realizing that change will always occur. Neither nursing nor the mankind we propose to serve benefits from calling in the media, the politicians, the special allies, and most important, the multiple coalitions who take sides for the wrong reasons--economic, power, or right to control. Without unity in what we do, no one wins. If persons dedicated to the associate degree route must denigrate baccalaureate education to exist, and there is no advanced study in nursing, then we have no need for master's and doctoral preparation. We should, if that be true, then give the public a clear sign that ADN programs are all that is needed. If, on the other hand, those in bccalaureate education state that those with associate degrees are not needed and do not have a role, then we must show that we have the quality and quantity to provide the total range of care required. Neither scenario makes sense. Neither educational pattern suffices for the scope and continuum of nursing needed.

What would make sense to many of us is that we work together to establish the best scenario to continue, validate, and expand our discipline, our knowledge, and our service. I do not believe that the best method for validation of what we are capable of offering is through the licensing and titling plan as now proposed by the American Nurses' Association. The issue is obscured in semantic red flags of titles. Regardless of the vote at the ANA Convention, I believe fervently that we must seek a better alternative. We must examine other option plans that will allow us to accomplish what both groups can accept without separating into camps. To our detriment we talk of the term R.N., a legal title, as if it were a degree. Changing occupants of the title will not change the historic meaning of the title. M.D. is a degree--doctor of medicine; the recipient is then licensed as a M.D. to be enabled to practice what the degree connotes. The scope of practice and the kind of expertise is denoted by post-licensure credentials and certifying boards. Surely we

can work for alternatives that have clearer meaning than the confusing manipulation of titles that is now proposed as a solution. Whatever develops, and even in the unlikely event that states would pass the enablement as the proposal now stands, where will we be except still divided? We shall still have to look at our separate and similar educational goals and results. We shall still have to develop the integrity of courageous peer evaluation.

While we are at odds, several extremely important issues are crying for our unified attention--education issues that will not be magically resolved by licensure and titling.

1. What is the essential body of content that forms the core base for all of nursing? How is it vertically and horizontally expanded to meet criteria of a profession?

2. What curricular changes are needed right now, in what programs, for preparation for practice in what settings, with what array of responsibilities and accountabilities?

3. How can students and faculty operate to assure effective learning experiences in a highly technological environment in which all caregivers are depending more and more upon impersonal, short contact indices of patient needs and responses?

4. What <u>is</u> the faculty role and the student's role on units that are well into primary nursing? Who then must be the teacher? How do students fit in for short periods of care without disrupting continuity of both care and accretion of knowledge and skill?

5. What is the real difference in clinical decision-making authority where primary nursing and clinical specialists are both present? How does the colleagueship operate?

6. What shared arrangements for teaching must be initiated between colleges of nursing and nursing service departments to assure continuity in learning? Even opportunity for meeting objectives?

7. With shortened patient stay, decreasing patient occupancy, over-utilization of clinical agencies by all educational programs, shifts of the chronic and very ill to non-hospital care sites, what is the clinical site of education for what students at what level in the future?

8. Can we all continue to give a little bit of everything and not enough of anything? Our programs may become like the description of the Mother Hubbard dresses of the missionaries, that is, to cover everything but touch nothing.

9. If there are finally only two routes of preparation, what consistent base can be established upon which to build? This is where we must develop shared projects and relationships with nursing services and ourselves.

10. Isn't it time to re-examine the faculty clinical teaching role? It has changed drastically and continues to change. What is happening to students and faculty? Are learning experiences chosen by what faculty can handle alone, often over several units, or by new arrangements based upon what students must know and manage?

These few questions represent my own dilemma. Whether or not they are yours, I believe that we can all agree that the whole matrix of education and practice is changing. We all need the shared partnerships that will move nursing forward in its goal--partnerships in education, partnerships with service, partnerships with consumers, partnerships with other health professionals. We must demonstrate our own "up front" deposit for partnerships before asking it of others. Could this be one of the causes of the dwindling pool of applicants, the lower enrollment, the choice of other less turbulent fields of study?

Unity of our complex organic whole of nursing education has always been desirable. Now it is imperative. We may falter. We may touch the sensitivity of one another. We may overreact. We may not, however, ignore the necessity of working through our problems together. As the Tri-Council found in our unified approach to legislation at the federal level, the gains were made because we did make some trade-offs before we went out of the room--we did present unity. As one senator said, "Don't come to us unless you're saying the same thing; we don't want to hear one side contradicting the other." Each of us here can have significant impact locally, regionally, and nationally in assuring the public that we stand for its interest if we will commit to the hard task of achieving "oneness of a complex, organic whole or of an interconnected series," respecting our differences, fostering our commonality. If we believe in assuring human dignity for patients, can we do less for each other? We have formed our peer group on the basis of the territory in which we operate, but not within the large framework of a nursing profession. Can SCCEN be considered an organization of professional peers who focus in different career patterns but have a compatible conceptualization of nursing?

I want to close my questioning, my sharing of concerns, with a quote and an admonition. First, some lines from Shakespeare's Macbeth that are worth pondering:

"Naught's had, all's spent, where our desire is got without content. It's best to be the thing which we destroy than by destruction dwell in doubtful joy."

Second, a worse ending could be the response of a public weary of our discontent, a public who like Rhett Butler could look at us and say, "Frankly, I don't give a damn," as it walks out. Let us please not let our fantasy and mooning over a dream and a time that never was the true thing make us lose a love of an accomplishment within our grasp--an excitement and a reality for the time that is now. Neither the illusions nor realities of the past can ever be re-structured, but the future can yet be. It can become a partnership--of education, service and the public--to achieve a level of health care desperately needed. That is the goal which we all share.